S. HRG. 102–580

HCFA REGULATION RESTRICTING USE OF MEDICAID PROVIDER DONATIONS AND TAXES

HEARING

BEFORE THE

COMMITTEE ON FINANCE UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

ON

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HCFA REGULATION RESTRICTING USE OF MEDICAID PROVIDER DONATIONS AND TAXES

TUESDAY, NOVEMBER 19, 1991

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Mitchell, Pryor, Rockefeller, Breaux, Chafee, Durenberger, Grassley, and Hatch.

[The press release announcing the hearing follows:]

[Press Release No. 49, Nov. 15, 1991]

BENTSEN CALLS HEARING ON MEDICAID REGULATION, FINANCE CHAIRMAN RECOMMENDS WITHDRAWAL OF PROPOSED RULE

WASHINGTON, DC—Senator Lloyd Bentsen, Chairman of the Senate Finance Committee, Friday announced a hearing next week on a proposed regulation that limits the ways in which state and local governments can pay their share of Medicaid costs.

The hearing will be at *10 a.m., Tuesday, November 19, 1991* in Room SD–215 of the Dirksen Senate Office Building.

Bentsen (D., Texas) said the hearing will cover the Health Care Financing Administration's (HCFA) proposed regulation, set to take effect January 1, 1992, restricting states' use of voluntary donation and taxes paid by hospitals, nursing homes and other health care providers.

"My position going into these hearings is that the Administration's regulation should be withdrawn. I'll expect Administration witnesses to try to convince me otherwise," Bentsen said.

"The regulation, which the Administration first issued September 12, was ambiguous enough to require two clarifications and an additional regulation—and the Administration is still debating with Governors the exact meaning of the language. While the Governors and the Administration made progress in resolving differences this week, it's uncertain whether that will clear matters up for health care providers and the states, which are facing an unanticipated loss of federal matching funds and changes in their budgeting for the coming year," Bentsen said.

"I am concerned about the Administration's allegations that states are misusing these funds. I want to make sure that taxpayers' money is protected but states must also be given clear guidance and time to adjust to the regulations. I have called on the Administration to join me in that effort—but so far it has shown too little regard for how the states will be affected," Bentsen said.

"The best policy is to sit down and work out a reasonable policy that addresses the Inspector General's concerns about possible abuses, yet takes into account the fact that millions of pregnant women, children, elderly and disabled Americans depend on Medicaid for needed health and long-term care. Their benefits should not be arbitrarily cut off because of the Administration's stubborn refusal to be reasonable," Bentsen said.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SENATE FINANCE COMMITTEE

The CHAIRMAN. This hearing will come to order. If you will please be seated and cease conversation. This is the Senate Finance Committee's second hearing on the administration's proposal to regulate ways in which States may finance their Medicaid programs by restricting their use of voluntary donations and provider-specific taxes.

Today we will also get a status report on the proposed compromise under negotiation between the administration and the National Governors' Association. And that, supposedly, would replace the administration's proposed regulations.

The administration should withdraw its regulation. At the very least, HHS should be prepared to freeze frame the issue, with the administration promising not to go forward with the regulation on January 1, and, most importantly, agreeing to keep any proposed savings out of the 1993 budget baseline. That way, over the next few weeks, the President's representatives, the Governors, and the Members of Congress can sit down and negotiate a reasonable solution of the problems raised by the Inspector General.

I will expect the administration's witnesses to try to convince me of why the regulation should not be withdrawn. That regulation was issued on September 12, and, without a change of heart by the administration, will automatically take effect on January 1, 1992.

At the best, the regulation is ambiguous. At the worst, it is overreaching and in violation of congressional intent. And by some, it can be viewed as a threat to the entire Medicaid program.

Six weeks ago, Chairman Dingell, of the House Energy and Commerce Committee; Budget Committee Chairmen James Sasser and Leon Panetta, and Subcommittee Chairmen Riegle and Waxman joined me in writing to Secretary Sullivan urging him to withdraw his regulation.

We offered to sit down with the administration and the Governors and address concerns raised by the Inspector General and the Office of Management and Budget. But the administration made it clear they would not withdraw the rule.

Just 3 weeks ago, and 7 weeks after the initial rule came out, the administration issued a long-promised second rule, supposedly replacing and clarifying the original. Unfortunately, it did very little to help.

Many States view it as more draconian than the original. Moreover, it was accompanied by a new proposed rule that would have further restricted the States' flexibility by number of hospitals that could receive special payments for serving especially large numbers of Medicaid, and other low-income individuals.

I understand that the administration is attempting to stop State financing mechanisms that it views as abusive. Let me make it perfectly clear: I share the administration's goal of halting any abusive practices that may be used with respect to Medicaid funding. I did not want to see one dime of revenue spent inappropriately. But I am deeply disturbed by the administration's refusal to withdraw the regulation.

If allowed to go into effect on January 1, it will cause a major, major alteration of the Congressional Budget Office and OMB budget baselines. And that will make it very difficult, if not impossible, to change the policy later without raising taxes, or forcing the sequester of $6 billion. And that would threaten such programs as Medicare, guaranteed student loans, and veteran services. The administration could avoid this by withdrawing the regulation and negotiating seriously with all the interested parties.

Medicaid is a very complex program. It is really 50 State programs, each with a unique set of benefits and ways of financing them. Without question, the States must operate within reasonable funding parameters. But these parameters should be established with care, accounting for the variation among States and their programs.

By issuing and refusing to withdraw a sweeping, ambiguous rule that automatically takes effect January the 1st, by failing to clarify that rule until 3 weeks ago, and by introducing a new and important issue into the debate at that late date, the administration has created an almost impossible situation for States, providers of care, and members of Congress who are trying to ensure that Medicaid works for its intended beneficiaries and that taxpayers are protected.

Our witnesses today will discuss ways to end and to prevent abuses that the Inspector General has identified, while making sure that States have the flexibility to fund their programs adequately.

I also want to hear their assessment of the proposal the administration and the Governors have developed, at least to the point they have progressed so far.

And most important, I would like the witnesses to describe the problems awaiting Medicaid recipients and the States if the administration insists on implementing its rule on January the 1st of 1992.

I now defer to my Senator friend from Minnesota. Oh. I beg your pardon. I did not see the Majority Leader come in.

Senator MITCHELL. Mr. Chairman, the Senator was here first. I do not——

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. A few comments while both of you are here, if I may.

Senator MITCHELL. Why do you not proceed, and then I will make my statement. I will leave after that.

The CHAIRMAN. Senator, go ahead.

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Thank you, Mr. Chairman. Mr. Chairman, first let me thank you for the hearing. Second, let me acknowledge the fact that we bear as much responsibility as anybody for the problem right here.

I met with the Governors' group 2 or 3 weeks ago and listened to them talk about how mandates on Medicaid have increased, without payments from the Federal Government, resulting in the

increased obligations States feel. I have a great deal of sympathy for that particular problem.

Mr. Chairman, I also know that by doing nothing, we, in the larger context, have exacerbated the problem. We have permitted the House at the end of each year to come along with this moratorium, which was a signal to everybody out there that this body is not going to do anything about a very obvious problem.

We have a few States taking advantage of voluntary contributions and/or donations. Not the legitimate taxes of a Florida, but voluntary contributions and donations which encourage all States to do the same thing. As we come together every single year we continue to say we are not going to do anything about it, we are going to moratoria, we are going to continue this moratorium. But, the other Governors and legislatures are pointing to the five or six which are "gaming the system," saying, hey, how about us? My State was one of these. Last April I got a call from the Democratic leadership of the legislature saying, hey, how about it? We just cannot afford this.

How about doing voluntary contributions, donations, some kind of a tax? I said, look out, because one of these days, we have to re-establish our relationship with State Government in the one program that has really tried to help low-income people access to health care.

Well, my State, like Texas and others, looked around, and in their desperation, they enacted some form of a donations and tax system. I remember calling over here, Mr. Chairman, to one of your staff and talking about Texas, because we are all very sensitive to Texas. I found out Texas was one of those States which was trying to do it right; trying to find out what the signals from the national government were and what should Texas be doing. Texas was facilitating the system whereby hospitals could donate services, for example, to make the Medicaid system work.

Now I know that Texas, like everybody else is looking at the rest of the country and seeing everybody doing it. Texas has now—and I think we will hear from the Governor—a very substantial system for moving their ad valorem taxes on hospitals at the local level, up to the State level and quintupling the amount of taxes at that level. Now Texas is part of the problem, as well. They were not 6 months ago, but they are today.

So, Mr. Chairman, my view of this, having watched it, as you have, develop, is we must take action. On behalf of every Governor, on behalf of every State Legislature, we have got to start setting some rules. I thought the administration's proposal needed modification; we all knew that. But I also felt if the administration were encouraged to abandon their proposal, then what is the reason for everybody getting together to try to work their way out of this. I saw the value in the administration keeping their proposal there to bring about the negotiations which I understand have been taking place for the last 3 weeks. Furthermore, I understand, and I hope we will find out today, that these negotiations are very close to bearing some fruit.

Therefore, as I listen very carefully to your statement, Mr. Chairman, on behalf of Texas, on behalf of Minnesota, on behalf of everybody, but particularly on behalf of 10 States which have not done

this yet, but are just waiting for the signals, we have a process which we can control and will lead us to a resolution of this problem by the first of the year.

If, for some reason, we do not have a resolution by the first of the year and we do not have a timeframe for people to adjust to it, then I think we are all in very serious trouble.

The CHAIRMAN. I turn now to the Majority Leader.

OPENING STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM MAINE

Senator MITCHELL. Mr. Chairman, I commend you for holding this hearing to address the serious problem of financing the Medicaid program.

On September 12, the Health Care Finance Administration issued an interim final rule that will prohibit States from using revenues from voluntary donations, provider-specific taxes, and intergovernmental transfers to pay for their Medicaid programs.

The implementation of this regulation will result in a serious erosion of the Medicaid program in many States, including the State of Maine. Health care services to poor women, children, and the elderly, will be jeopardized if these proposed regulations are implemented.

I repeat what I have said previously on many occasions. I call upon President Bush to withdraw these regulations. They violate both the statute and the intent of the Omnibus Budget Reconciliation Act of 1990.

The use of provider-specific taxes was clarified in that Act. The statute allows States to use revenues from taxes applied to hospitals or other health care providers as part of the State's share for Federal matching payments.

That reconciliation bill made one exception: matching funds are not available for costs attributable to provider-specific taxes in cases where States reimbursed hospitals and other facilities on a cost basis.

The September 12 rule by HCFA expands this exception into a broad prohibition of the use of most revenues from provider-specific taxes. Since the September 12th rule was issued, there has been a great deal of confusion about the impact of the regulations on individual States.

The administrated admitted that the regulations were unclear and confusing, and promised to issue a clarification. On October 29, the clarification was issued, but it does not seem to have shed much light on the impact of the regulation on the States, and the situation remains confused.

During the last several weeks, the Governors and the administration have been engaged in negotiations in an effort to reach a compromise. Thus far, they have not been successful. The administration argues that State donation and tax programs have the potential to undermine a basic premise of the Medicaid program, that funding be shared through a Federal match of State monies.

The Governors argue that the Federal Government has no authority to dictate to a State how it may raise State revenues to be used in meeting Medicaid matching fund requirements.

I believe that there are some abuses of the program in some States, and that those should be corrected. However, the administration is attempting to implement a broadly based prohibition against all tax plans in all States, and clearly, this violates the congressional intent contained in the 1990 Reconciliation Act.

The administration, the States, and the Congress are all concerned about the dramatically rising costs of the Medicaid program. We must also be concerned about the legitimate need to provide access to basic health care for our Nation's poorest citizens.

HCFA Administrator, Gail Wilensky, made the following statement in an October 16, 1991 letter to Representative Waxman. I quote, "I know that many States, for the most part, have been using the increased Federal funding to support legitimate, and often necessary expansions to their Medicaid programs."

So, there is no question but that what is being done with the funds is to meet important and legitimate needs in each of the States.

In my own State, the situation is critical. In the past 5 years, the number of Medicaid recipients in Maine and their costs have risen dramatically.

In the past 18 months alone, due to a very severe downturn in our State's economy, the number of Medicaid recipients has increased by more than 25 percent in just the past 18 months.

The program's expenditures have doubled in Maine since 1986. The State's share of spending in the Medicaid program has risen 35 percent in proportion to overall general fund expenditures in the same period.

The Maine Department of Human Services, working with HCFA's Region I office, developed a provider-specific tax plan as a responsible way to meet the health care needs of Maine's most vulnerable citizens. The result of the HCFA regulation will be to prevent use of that tax plan after January 1, 1992.

The financial impact of the interim final regulation jeopardizes over $62 million in fiscal year 1992, and creates a shortfall of over $48 million in the State's fiscal year 1993 budget.

Clearly, it is in the best interests of all parties to continue to work toward a compromise which can be agreed upon by the Governors, the administration, and the States, but time is running out.

Congressman Waxman has introduced legislation in the House which would prevent HCFA from implementing the September 12 rule by extending the moratorium until September 30, 1992.

While the Congressional Budget Office scores this legislation at zero cost, the Office of Management and Budget scored the bill at $1.5 billion a few weeks ago, and now is up to $5.8 billion at the latest count, demonstrating once again the political flexibility of that organization.

If an acceptable compromise is not reached very soon, legislation will be necessary to delay the implementation of the rule until a compromise can be reached.

I look forward to the testimony of Dr. Wilensky, Governor Richards, and the other witnesses here today, as we continue to work together toward the common goal of providing basic health care services to our most vulnerable citizens.

And I conclude as I began, Mr. Chairman, by calling upon the President to withdraw this unwise regulation.

The CHAIRMAN. Thank you, Mr. Majority Leader. Senator Grassley, would you care to make some comments?

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Yes, Mr. Chairman. I appreciate that very much. I am glad for the expert witnesses who are here today, and particularly I am glad to hear representatives of organizations which have a stake in our Medicaid provider tax and voluntary contribution issue.

Now, Mr. Chairman, to the best of my knowledge, my State of Iowa does not engage in the funding methods at issue here. However, that does not mean that Iowans have not followed this issue.

I would like to quote just briefly from a Des Moines Register editorial: "Thirty-seven States are cheating the Federal Treasury out of health care money, aided and abetted by the U.S. Congress. Iowa is not 1 of the 37, but its honesty is costing its residents millions upon millions of dollars."

Now, that is an awfully strong comment, Mr. Chairman, but that is, at least, what our leading newspaper has to say about this issue.

Now, I had a chance to visit with our Iowa Medicaid director. He informed me last week that the State of Iowa supports the agreement apparently reached between the Governors' Association, and HCFA, and OMB, or, because an agreement seems to have been an off-again, on-again thing, they support an agreement. The Iowa director also said that he does not support the idea of a moratorium.

Although I want to review the testimony presented today before coming to a judgment, I am concerned about some of the methods some of the States are apparently using to increase the Federal share of Medicaid revenues.

If the descriptions provided by HCFA of some of these methods are accurate—and I am willing to reserve judgment to see if they are—it does seem to me that they clearly circumvent, at least, the intention of the law.

I am referring here to situations in which providers give a voluntary contribution or pay a tax to the State's Medicaid program, but get money back through higher reimbursements. The end result is to make it look as though the State has increased its contributions to the Medicaid program, thus allowing it to draw down a higher number of Federal dollars.

In these arrangements, the only party paying more is the Federal Government. The Health Care Financing Administration maintains that it is, at least theoretically, possible for the Federal Government to end up paying 100 percent of the State's Medicaid bill.

So, I am hoping, Mr. Chairman, that our witnesses today will clarify for us whether, and to what extent, the States are using such methods and will provide a convincing justification for the use of methods which seem, at least, to contravene the intention of our law.

The CHAIRMAN. Thank you, Senator.

Senator Pryor, do you care to make some comments?

OPENING STATEMENT OF HON. DAVID PRYOR, A U.S. SENATOR FROM ARKANSAS

Senator PRYOR. Mr. Chairman, I have a longer statement for the record, but I will try to do this in 1 minute.

Last spring, Mr. Chairman, my colleagues, the State Legislature in Arkansas adopted a 15 percent tax on the Medicaid payments that they received from the State.

The revenue from this tax certainly will not replace the State's Medicaid general revenue obligation, but we think this was a very, very fair approach to the whole problem. We thought it had been accepted.

Our Governor Clinton and all the members of the Legislature, and all those involved had no problem with this particular plan. It was working well. And now, we find that HCFA is reinterpreting all the regulations and trying to basically destroy this relationship in this particular provision.

So, Mr. Chairman, I think that we are very fortunate today to have the Governor of Texas, Governor Richards, and others, who are going to tell about their respective States. I wanted to tell just a moment about mine. I have, once again, a longer statement for the record, and I hope we can rectify this problem immediately. Thank you, Mr. Chairman.

[The prepared statement of Senator Pryor appears in the appendix.]

The CHAIRMAN. Thank you, Senator. Senator Breaux, would you care to make a statement?

Senator BREAUX. Mr. Chairman, in deference to the process, I will just file my statement. Thank you.

The CHAIRMAN. Thank you. We are pleased to have Senator Graham here this morning, the senior Senator from the State of Florida, who, as a Governor, has been intimately involved in these concerns and has knowledge and depth of the issues. And if you would come forward and make any comments.

STATEMENT OF HON. BOB GRAHAM, A U.S. SENATOR FROM FLORIDA

Senator GRAHAM. Thank you, Mr. Chairman. In recognition of the long witness list that you have of distinguished Americans who wish to speak on this issue, and your generosity in the past in allowing me to testify before the committee, I would request permission to file, for the record, my full statement, and will make a few summary remarks.

The CHAIRMAN. Without objection it will be entered.

[The prepared statement of Senator Graham appears in the appendix.]

Senator GRAHAM. Mr. Chairman, we return again to the issue of the Federal Government's interpretations of the States' intentions relative to the imposition of provider-specific taxes.

The history in my State, which I think is paralleled in most others, is that we found in the early to mid-1980's several patterns developing. One of those patterns was that only a few of the hospitals in the State were carrying the burden for indigent care. Second, we

found escalating Medicaid costs. Florida's response to those two circumstances was to adopt a provider-specific tax on total net income of hospitals. Hospitals would pay 1.5 percent into a State-administered fund, which would be used for a variety of indigent care programs. The fund was not used for Medicaid exclusively, but Medicaid and other programs directed at the indigent community.

The purpose of this provider tax was to assure that all hospitals would be participating, at least to that extent, in indigent care. It was a program which was eventually supported by a large majority; the legislature, public interest groups, and the provider community. It has worked well and has been well-received in our State.

I became concerned after coming to this institution with allegations made against these types of programs in general, and the undifferentiated nature of those claims.

I appreciate the specific reference that the Senator from Minnesota made, in which he recognized that there were differences, and his kind comments about the Florida program.

In expression of that concern, I introduced legislation to provide for continued provider taxes and donations with certain restrictions. That became the subject of negotiations between the House and the Senate, and resulted in the OBRA legislation of last year.

The final resolution of that was a compromise, which basically had two parts. First, the Secretary was denied authority to deny or limit payments to a State for expenditures for medical assistance, for items or services attributable to taxes, whether or not a general applicability imposed with respect to the provision of such items or services.

And second, there is an exception specifically requested by the administration which denies Federal Medicaid matching funds for payments to hospitals and other institution providers for the cost attributable to taxes imposed by the State solely with respect to hospitals and facilities.

When Dr. Wilensky presented these provisions to me during the negotiations, I contacted the Florida Medicaid director, who then spoke directly with Dr. Wilensky. The extent of all of our conversations was entirely on the subject of attributable cost.

Mr. Chairman, the regulations which have been submitted go well beyond that statutory authority, which have been specifically and very carefully developed. These regulations could have a devastating effect on my State, and on the other States, as indicated by the members of this committee.

Mr. Chairman, I would like to request permission to submit for the record a letter from Governor Lawton Childs, outlining the specific effect of the regulation on the State of Florida.

The CHAIRMAN. We would be delighted to have that.

[The letter appears in the appendix.]

Senator GRAHAM. Mr. Chairman, I would hope that we could resolve this matter in the few days remaining in this session. If not, I would urge this committee to adopt a moratorium against the implementation of these regulations for a further period of time, such as through the balance of the current fiscal year, to give the time for continued negotiations among the Congress, the States, and the HCFA Administrator.

Mr. Chairman, I appreciate your generosity in time, and, as indicated, will submit a full statement for the record.

The CHAIRMAN. Senator, thank you very much for recounting your personal experience and your involvement in it, and your depth of knowledge on this issue. I would say that I strongly agree with you. I hope we can resolve the differences amongst the Governors, and the administration, and the Congress in these last few days of this session.

I would prefer not to have another moratorium, if we could do that. But if we do not, then I would propose a short one to keep the pressure on all sides involved to try to come up with a satisfactory solution. Thank you very much for your testimony.

Senator GRAHAM. Mr. Chairman, I appreciate those remarks. And if I could just conclude with a final observation.

This is a time in which all elements of the Federal system—the national government and the States and local communities—are under tremendous financial stress. That is a reflection of the distress of individual Americans, and the fact that they depend upon governments at all of those levels for important, basic services, such as the indigent care provided through Medicaid, which is primarily to young children, to mothers, and to elderly persons in this country.

I would hope that we better serve the people of America than to fall into petty bickering and attempts to avoid responsibility; that we use these difficult times as a challenge to unite our Federal system in an effective cooperative effort to meet the needs of our people.

The CHAIRMAN. Thank you.

Senator GRAHAM. Thank you.

The CHAIRMAN. The Senator is right. It has been a difficult time for the Federal Government and the State Governments. We have had an economy that is dead in the water. That means that tax collections have not been at the level that had been anticipated, and, therefore, the deficits have increased.

Our next witness is the distinguished Governor of Texas. My good friend, who has just shared the experiences of Governors across this Nation in trying to work out deficit problems, taking care of the concerns of the States and their constituencies. And we are delighted to have her here this morning. She has been in negotiations with HCFA, and the administration, the Executive Branch, as late as last night, I understand. And so, I do not think we can get more up-to-date reports as to how the negotiations are going. Governor, do you want to tell us about it?

STATEMENT OF HON. ANN W. RICHARDS, GOVERNOR OF THE STATE OF TEXAS, AUSTIN, TX, ACCOMPANIED BY ALICIA PELRINE, DIRECTOR, COMMITTEE ON HUMAN RESOURCES OF THE NATIONAL GOVERNORS' ASSOCIATION

Governor RICHARDS. Thank you very much, Senator Bentsen. It is always a pleasure to get to see you again. Members of the committee, I thank you for the opportunity for allowing me to express the problems associated with the imposition of these new rules on the States.

Let me say, Mr. Chairman, that we are always hopeful that we can come to an agreement with the administration to resolve this problem. And the negotiations were continuing last night, and I am very, very hopeful that we will be able to resolve it.

Should we not be able to do so, I would suggest that you might consider some period of time in which the States and the administration be given some leeway to attempt to come to some successful conclusion. I really appreciate the opportunity to come before you this morning to address the committee about Texas' concerns regarding the proposed funding rule changes.

You and I know that the debate over these rules is a result of a collision of an immovable object and an irresistible force. The immovable object is the Federal budget, as constricted by debt, and the budget agreement.

And the irresistible force is a national demand for access to health care. It rises not from the political parties or from interest groups, but from the real lives of individuals and businesses that are being bankrupted by a health care system that lavishes care on those that can pay, provides the basics to the poorest of the poor, and leaves the majority of us worried that we cannot afford the cost of good health. The old highwayman's demand, your money or your life, has taken on a whole new meaning in America today.

So, while we are up here discussing funding formulas and tossing around acronyms—like HCFA, and OMB, and DISPRO-1, 2, 3, and all of the rest of the unpalatable alphabet soup that government has become—normal people can be forgiven if it all looks like another endless discussion about how many angels can dance on the head of a bureaucrat's ballpoint pen.

We, in the States, share that frustration. In 1965 when the Federal Government took the first tentative steps toward a national health care policy with the creating of Medicare and Medicaid, we were all truly rejoicing.

Over the years, those programs have grown in complexity, expanding the bureaucracy, and the regulations involved. And as the States have taken on a larger role, we have had to depend on the Federal Government to act in a cooperative way. We have done our damndest to comply with the regulations to do what the Federal Government has told us to do.

In Texas, our spending for Medicaid in 1984 was $691 million. We did not ask the Federal Government to recognize our specific method of taxing that made us eligible for more monies to serve the uninsured poor until 1989; only 2 years ago. The best estimates tell us that within the next 2 years, our share of that cost will be $2.5 billion.

We are committed to finding that money, and funding our fair share of the program. But now we are told that what we have done with the latest round of regulations does not fit into the preconceived notions of OMB, and, therefore, the rules are going to be changed after the fact.

In the new rules, and if they go into effect, Texas hospitals that carry the heaviest load of uncompensated health care will lose almost $1 billion in disproportionate-share funding in this biennium.

I do not want to be difficult in suggesting to you that this action is tremendously unfair and ill-timed. I certainly do not want to

think that there is an attempt to renege on a commitment to the States, but that is how it would appear.

These proposed rule changes will not cut just the heart out of State budgets. They will break the hearts of real, live human beings who need the care that would have been provided under the existing rules, and who are counting on their government to live up to its obligations.

A young family that experiences job change and then has a lapse in benefits because mother's pregnancy is not covered under the pre-existing condition; and the mother who cannot meet the cost of the insurance co-payments to pay for her child's hospitalization; the grandfather who lost his job and cannot pay for glaucoma treatment and is facing the choice of blindness, or exhausting his kids' savings. These are the people who will be affected by the rules changes. They and the hospitals that will be asked to absorb the cost of their care that will face the choice of turning people away, or threatening their own financial existence.

We know the numbers. There are 37 million Americans with no health care coverage of any kind. Four million of them are in Texas, and half of them—half of them are working at full-time jobs. I am not suggesting that any member of this Congress is not deeply concerned about these people, because I think you are.

But I will point out that nowhere in these rule changes or policy initiatives do we find the word "patient," do we find the word "human being." Do we recognize that we are talking about people and their lives?

And when we get caught up in one more round of tinkering on the margins of the formulas, it can seem to people that not only have we lost sight of them, that we have taken leave of our senses.

You and I can sit here and deliberate all day about the formulas, and the mechanisms, and the percentages, and whether you call it a donation, or you call it a tax, or you call it Mildred. [Laughter.]

But the people out there—the people out there are paying the price. The fact of the matter, gentleman, is that we all have the same taxpayers. Those taxpayers do not especially care whether the money comes from your budget or our budget. They just know it comes out of their pocket no matter which budget you are talking about. And most of those pockets are empty.

And I think those same taxpayers are going to have a lot of trouble figuring out how the Federal Government can spend $1,491,563,000 a year; can, in fact, have an annual deficit that is larger than the combined budgets of all 50 States; and I think that Texas taxpayers have a real hard time figuring how State Government spends $59.5 billion a year and increases taxes every year for health care purposes, but we are accusing each other of financial skullduggery and arguing over formulas, and shaking our fists, rather than finding ways to pay for the one thing that everyone agrees that we need, which is decent health care.

I firmly believe that every member of this committee wants to do what is best for this country, and to deal with the States in good faith. And to get us past this immediate problem, I urge you to support legislation that includes three basic principles.

Number one: We must have a system that allows the States to determine our own method of inter-governmental transfers. We, in

Texas, do not have a State-wide hospital tax; never have had. We raise our revenues through local hospital districts. Always have. And the local taxpayers are contributing more than a fair share.

The Parkland Hospital District in Dallas, for instance, has raised its ad valorem taxes 27 percent in the last 2 years. And Houston taxpayers have experienced a similar increase. These local taxpayers have a right to a Federal support for their tax effort.

Number two: We do not want another open-ended Federal spending program. We do not want that any more than you do, and we understand that you may need to cap the amount that you send to the States for the disproportionate share program. You may have to be able to identify specifically how much money you can spend on that program.

But if you are going to put a cap on, you have got to give us the flexibility to raise the money and spend the money in the way that works best within our individual States. Combining caps with some kind of strict, one-size-fits-all restriction, is a prescription for failure of the limited health care programs that we have got.

And number three: We must have a provision that requires rules that are made, will stay in place for a complete budget cycle.

A change in the rules after the States have constructed their budget is like throwing gasoline on the flames of the public perception that government cannot get its act together, and cannot stick with anything long enough to make it work.

And such changes throw State Governments into chaos, requiring special sessions, where the outcome is dubious, at best.

So, the bottom line is that we need a permanent legislative solution. But if we cannot get it in the short time before the Thanksgiving recess, we need some form of veto-proof period of time in which we can resolve it.

I appreciate the time very much that you have given me today, and I am happy to attempt to answer any questions that you have. But in case my limited knowledge in this rarefied atmosphere within the Beltway cannot address all of your questions, I have got staff with me that can.

The CHAIRMAN. Governor, you behave. [Laughter.]

When you talk about a budget cycle, you are not talking about 1 year. You are talking about 2 years, I take it.

Governor RICHARDS. Yes, sir. Yes, sir.

The CHAIRMAN. About the other problem on disproportionate share hospitals. I understand that the negotiators for the NGA had been holding out to have the authority to designate any or all of their hospitals as disproportionate share, and that defies, really, common sense. But I take it from what you are saying, that is not your viewpoint.

Governor RICHARDS. Alicia Pelrine, who is here with the National Governors' Association, has been a part of all of the negotiations with the administration and with the various Governors; I have not, Senator.

One of the things we have tried very hard to do in Texas, and my assumption has been that that is the intent of the Federal Government as well, is that we have tried to encourage our hospitals in Texas to take all comers.

The CHAIRMAN. I understand. But when we talk about disproportionate share——

Governor RICHARDS. Yes.

The CHAIRMAN. They cannot all be doing a disproportionate share. There must be some kind of a limitation, whether it is 50 percent, the top 50 percent, or whatever it might be. Some kind of——

Governor RICHARDS. Yes. And we have limited ours, Senator, I believe, to the top 25 percent.

The CHAIRMAN. All right. Yes. But I had heard that the negotiators for the Governors were trying to see that the States had full authority to designate any or all of them.

Governor RICHARDS. Alicia, can you help him there?

The CHAIRMAN. And you cannot have them all having a disproportionate share.

Ms. PELRINE. Senator, what we have attempted to preserve in the negotiations, in exchange for agreeing to a cap on payments for hospitals that are serving low-income and Medicaid clients, is current law flexibility for States to decide how to designate those hospitals that they want to participate in the disproportionate share program.

So, our settlement agreement at this time incorporates current law with respect to how those designations are made at the State level. It does not eliminate that language in current law which says that hospitals must be providing services to low-income people, or to people who are eligible for Medicaid.

The CHAIRMAN. Well, I think you are going to end up with some kind of cap. I think you will have to have it.

Ms. PELRINE. And we would agree, Senator, that a cap is an important component of the agreement.

The CHAIRMAN. Thank you. Senator Durenberger.

Senator DURENBERGER. If I might follow-up on that question, and, if I may, Governor, address a question to Ms. Pelrine.

Governor RICHARDS. All right.

Senator DURENBERGER. Is it not a fact that under current law, States can go up to 100 percent of their hospitals, as the Chairman indicates? Is Maine not an affected 92 percent already, so, in effect, have we not written a license to all States to classify all their hospitals as disproportionate share?

Ms. PELRINE. There are some States who cover significant numbers of their hospitals through their disproportionate share program. There are States, for instance, like New York, who have made a policy decision that all hospitals in the State have to take all comers.

Their feeling is that that those hospitals need to have some sort of a compensation for the numbers of uninsured people that they serve, some of whom are Medicaid-eligible; many of whom are not.

So, those States in which a large number of hospitals are disproportionate share hospitals usually reflect a policy decision of that nature on the part of the State.

Senator DURENBERGER. Well, I will just be precise and answer in the language folks out there can understand, not the alphabet language. The fact of the matter is if 50 States make the decision, Texas is being reasonable. They stopped it at 25 percent.

But, if everybody is going to do what New York is going to do, and say all of our hospitals must accept all comers—which most hospitals do anyway, but as official policy—then is it not a fact that under current law you can have every hospital in America designated as a disproportionate share hospital?

Ms. PELRINE. I do not believe that is possible under current law, Senator. But, in addition, the way we would respond to that is to agree that there ought to be a limit on the amount of money available for payments to those hospitals which States do designate as disproportionate share, which is another way of getting at the same problem, and that is an uncontrolled growth in that particular program.

Senator DURENBERGER. Governor, if I might ask you a question. There is a lot of good material in your statement. The best one comes right at the end when you are talking about the taxpayers we all represent having a lot of trouble figuring out how a Federal Government, with $1.5 trillion in debt, can have a deficit larger than the combined deficits of all of the combined budgets of all of the States.

I think this is the reality. Also, I think, this is because you have to do a lot of needs-testing and we do not.

We have 60 percent of our Federal budget as an entitlement program where we are transferring money on the basis of commitments made back in the 1950's, trying to deal with the realities of the 1990's. Except that does not satisfy the taxpayers.

My question is, we tried to struggle with this back in the early 1980's. The last time we had something called a "New Federalism," I happened to be Chairman both of the Health Subcommittee here, and the Inter-Governmental Relations Subcommittee. With the help of our dear, blessed, late Governor Dick Snelling, we almost worked our way up to the point where we could have straightened out some of these relationships, but it did not work out.

At that time, one of the key questions was the way in which the Federal Government would participate in meeting the needs of low income persons in the States.

In other words, you might want to put more money into highways, or treatment plants, and so forth, State by State. But when it comes to people, people do not have a lot of choices anymore about where they live.

So, we all felt it was a national obligation to guarantee some kind of minimal access to services for every American, regardless of whether they lived in Texas, Mississippi, Minnesota, Arkansas, or wherever. We struggled with how best to do it, and we are still struggling with it.

Governor RICHARDS. Sure.

Senator DURENBERGER. The current system in Medicaid, just looking at that part of it, is a system of matching. This is our problem. You spend so much in tax effort, and we give you so much.

Governor RICHARDS. Yes.

Senator DURENBERGER. Now, what we are doing is not only taking the general taxes—your ad valorem taxes, your transactional taxes, and your income taxes—but now we are taking taxes on the services which these matching taxes pay for—i.e., the sick taxes, and we are using them to match.

Now, I am just concerned about what your instinct tells you about the most appropriate relationship we ought to have. Is this a good way for us to determine how much money goes into the low-income health needs of Texans? Or should we continue to struggle to try to find some kind of a formula by which this government can annually guarantee to the people of Texas X number of dollars, to help Texas provide for the low-income health needs of its citizens?

Furthermore, struggling with your own tax capacity, with your local and State tax effort and the number of low-income people, this is something that the inter-governmental community struggles with all the time, but never seems to come up with an answer. I wondered if you had any instinct which would tell you how we ought to start moving from this matching game that we have been playing, into something much more predictable in terms of our relationship.

Governor RICHARDS. Yes, sir. I have thought a lot about it. My assumption has always been that you in the Federal Government are dealing with those of us in States that all have different history, that all have different fashions in which we have decided to get money for whatever purposes, and, in doing so, you are playing a very difficult jigsaw puzzle kind of game because the States are all so different.

My assumption has been that there would have to be, based on some rationale, a cap placed and that we would have to accept that. But in return, you would have to accept our differences.

And that we would, by what devices we can, historically and by tradition, try to provide the match monies that are necessary for you within whatever that cap is.

Now, a formula is going to be fine. There is only one small glitch, and that is that you have got to recognize the fact that all of our areas are not the same, and you in Minnesota particularly can appreciate the difference between rural life and urban life.

So, if there is a formula devised, that formula must take into account what is happening in rural America, and the need for rural health care, and the problems with rural hospitals.

Rural hospitals simply cannot come up under a formula in the same kind of funding that urban hospital can. And with that caveat, I will tell you that I think that my fellow Governors will agree to some formula mechanism.

The CHAIRMAN. Senator Pryor.

Senator PRYOR. Yes. Thank you, Mr. Chairman. Governor Richards, I am not a defender, nor one of the people who really get up and beat the desk on behalf of HCFA, but I must say this, and I am learning this as the morning progresses. We may be talking about the wrong culprit here. We have HCFA, they are going to testify—Dr. Wilensky is.

But it is my understanding that OMB may be, in fact, the culprit. They may have pressed HCFA to take the rap and to make this decision. OMB hides in the dark; HCFA's neck goes in the noose. We asked, it is my understanding—Mr. Chairman may want to correct me—Mr. Darman, or anyone else from OMB to come this morning and testify before this committee, and they refused. We said, all right. We will reset the date. We will reset the date, OMB, for your convenience. They still refused.

Now, they are not here up at that table where you are, and where Dr. Wilensky is going to be. But you better believe they are sitting out here in this audience.

They are the ones who should be here answering to this committee and to the Governors of this State that you are so ably representing this morning, and they are not here. They are hiding in the shadows. And to me, that is unthinkable. And I think they should be reminded that legislatures like we have in Arkansas will not even be meeting next year. We meet every 2 years.

Governor RICHARDS. Right.

Senator PRYOR. And they are not sensitized to this, and I think it is unthinkable and despicable, as a matter of fact, for them not showing up this morning and coming out here and really defending their position, because it is their position. It may well be HCFA's also, but it is definitely OMB's.

Governor RICHARDS. Thank you, Mr. Senator.

The CHAIRMAN. Amen, brother. [Laughter.]

Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman. Thank you, Governor. We are delighted to have you back in Washington with us. I want to ask maybe just one question. Maybe your staff or you could respond. I take it that Texas has a provider tax or a voluntary contribution program?

Governor RICHARDS. Yes.

Senator BREAUX. Can you tell me if it covers all of the services that the hospitals provide, or just the Medicaid services?

Governor RICHARDS. It provides all services. And without getting into the complexities of it, Texas made the decision in the last session of the legislature to expand our services in Medicaid to 185 percent of poverty. In 5 years, we have doubled the amount of State money that we have put into these programs. By 1992, we have committed $6.3 billion.

Senator BREAUX. But the taxes that the State of Texas levies on these providers are based on all the services that these providers provide, not just Medicaid services.

Governor RICHARDS. Yes, sir. Oh, yes, sir.

Senator BREAUX. All right. Thank you. Thank you, Governor.

Governor RICHARDS. Absolutely.

Senator BREAUX. Glad to have you.

The CHAIRMAN. Senator Hatch.

Senator HATCH. Welcome, Governor. We are glad to have you here. Could I just ask you one question?

Governor RICHARDS. Yes, sir.

Senator HATCH. You know, it dawns on me that if we are ever going to have a comprehensive health care approach in this society, that perhaps one of the problems is the cost of Medicaid and the overlapping where the States have to do this or that in order to comply with this or that imposed upon them by the Federal Government.

I have wondered if it might not be an appropriate thing to ultimately—and I am not sure where we should be on this—if we should not just make Medicaid the sole responsibility of the Federal Government. That would get rid of some of these problems. We could also offset by having the States have the sole responsibility

for some other program. For instance, I have been looking at the catastrophic area for the States. But, I would like to consider federalizing Medicaid so you do not have this overlap and these constant conflicts between the two sources of funding.

Have you given any thought to something like that? Now, that is just one little part of an overall comprehensive national health program, but it seems to me it would make sense, rather than continually getting into this constant battling over who does what with regard to Medicaid funding.

Governor RICHARDS. Senator Hatch, we have all given a great deal of thought to what is going to have to happen in health care in this country. Not only should the responsibility be borne from one source; should we have a plan of national health insurance and would that really resolve it, and I do not know the answer to that.

I do know, though, that the Governors that I think now preside over what are described the laboratories of democracy, would be happy to look at a proposal for the Federal Government providing for all of Medicare and Medicaid. And, in exchange, we would like to know what our responsibilities might be in another area. We are not adverse to working hand-in-hand with the Federal Government as we have done for a very, very long time.

Senator HATCH. Well, thank you. I think it is something we have to look at. If we are going to have the Federal Government in a role of a major health care provider, which it is, it is clear to me that Medicaid has to be reformed. Maybe one of the reforms would be to give the responsibility for Medicaid to the Federal Government while we shift some other responsibilities to the State for them to have the sole responsibility over and which they are more capable of handling.

Let me just ask you one other question. How close are you Governors to resolving the problem with HCFA that we are talking about today? Is it very close? Would a small moratorium—a short time, like the Chairman has suggested here—allow you to get it done. I have a tendency to want to support my Chairman on these matters.

Governor RICHARDS. Senator, last night I got in here very late, and the staff advised me that we are very close to coming to an agreement. And I hope that we will be able to say to you that we have done so, if not today, in the morning. We are going to try very hard to do that.

If, however, we are unable to do it in this period of time, I would urge you to give us a little more time, because I think we are very, very close to being there.

And I would suggest in your discussions with the administration this morning, in their testimony to you, I think that they will verify that. At least, that was the way it was represented to me when I got in here last night.

Senator HATCH. Well, it seems to me you have made a powerful statement here on behalf of people who are injured and people who are having difficulties. This is not just a conflict between the State and the Federal Government. And, it seems to me we have got to resolve the problems in the best interests of the people who are hurting out there.

Governor RICHARDS. Absolutely.

Senator HATCH. But then we have got to think of it in a larger context as we go into next year's big battle over health care reform. I hope it is not a battle. I hope we can come to a bipartisan conclusion on what best should be done to resolve the health care problems of our country as a whole, while still allowing the principles of Federalism to continue.

So, I want to tell you I have been impressed with your testimony today.

Governor RICHARDS. Thank you.

Senator HATCH. I appreciate you coming today. These are matters that concern me greatly, and I hope that we can help both sides to come together and get this issue solved. I think the Chairman is right. If we give them a short period of time then we can keep the pressure on both of them. Yet, let us get it done so that it is in the best interest of everybody concerned.

The CHAIRMAN. Thank you.

Senator HATCH. Thank you.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Mr. Chairman, thank you. Governor, I may have missed this, but I would be interested in hearing if the HCFA regulations are, in fact, put into effect, what happens in Texas, who is affected, and in what ways?

Governor RICHARDS. If the existing regulations are put into effect, it would jeopardize about $1 billion, Senator, in monies that would be coming to the State of Texas in the form of Federal match dollars. In the State of West Virginia, I think it places in jeopardy about $42 million for your State.

Senator ROCKEFELLER. All right.

Governor RICHARDS. And I do not want to get too complicated about this, but I will tell you what the real deal is. We were given specific rules by the Federal Government that said, this is what you have got to do if you are going to be able to get money from us. And we said, all right. And we sat down with those rules and we devised a plan under the present taxing system of Texas.

And we sent it up here, and everybody said, that is fine. And then in the middle of the game, everybody went, time out, we are going to change the rules, and now you cannot do what we said you could do.

And that occurred at a time when it was my understanding that the Congress had an agreement from OMB that there would be at least a year's period of time before they would talk about any rules changes. And then all of a sudden, there was a flip-flop, and we are told, no, we have got a new set.

So, what the Governors are trying to ask you all to do is to stick to the rules that you agreed on through the budget cycle, and do not force us in a position to have to call special sessions to try to make up for what we have committed to.

And what we have committed to does not have anything to do with these pieces of paper on which numbers are written. They are human beings. We are talking about people who are not going to get health care.

We are talking about people who are sick, and have children who are sick, and we are going to have to close the doors and say, no,

the Federal Government changed the rules, so we cannot care for you anymore.

And they do not accept that answer. They do not believe that the Federal Government would be so insensitive. And I am really not trying to over-sensationalize, but that is essentially what we are dealing with.

Senator ROCKEFELLER. Governor, I am glad you expressed it that way. And in both Medicaid and Medicare, one of the problems is that the recent administrations see those as enormous pots of money, which, of course, they are, and they have relatively unvocal constituencies. And so, they are really good targets to get money from.

I sat on the conference committee that laid out what this deal was meant to be last year. I know very well what the legislative intent was, and it was not what is now happening.

Governor RICHARDS. Yes, sir.

Senator ROCKEFELLER. I share your view. Can I ask you one additional question. From my own personal view, I do not think Medicaid should exist at all. It should be replaced by a much better public program.

But within the present context, would you, as a Governor, be willing to exchange, let us say, an enhanced—Medicaid match, in other words, the Federal Government contributing a little bit more—in return for uniform eligibility requirements, reimbursement levels, and benefits.

Governor RICHARDS. Does that translate, Bruce, into the broad-based taxes? Is that what he is talking about?

Senator ROCKEFELLER. It is a purely theoretical question.

Governor RICHARDS. All right. This is Bruce Lesley, on the staff. And since you all speak a language that is not immediately translatable to me——[Laughter.]

Senator ROCKEFELLER. All right. In other words, if the Federal Government were to pay States a higher Medicaid match rate would the Governors be willing, in exchange, to accept uniformed eligibility requirements among the States? In other words, States now set eligibility under AFDC requirements——

Governor RICHARDS. Right.

Senator ROCKEFELLER. And they vary enormously——

Governor RICHARDS. Right.

Senator ROCKEFELLER. Among the States. And, also, the same kinds of benefits.

Governor RICHARDS. Senator, it would be very hard for me to commit other States.

Senator ROCKEFELLER. I know that. I am just asking you.

Governor RICHARDS. Our problem is that we all have our systems that have been set up at different points in time, and that there is some historic differences. And so the States ask for flexibility under the agreement that if you have to have a certain amount that you want to write down on your budget line, that is all right with us.

We will live within the constraints of the amount of money. But give us the flexibility within the State, both to produce the money, and who we cover.

Senator ROCKEFELLER. I understand that, Governor. But part of the flexibility that States now have—for example, is for the State of Alabama—and I am not sure if these are current figures—to set eligibility for AFDC at, for example, 14 percent of the level of poverty.

Governor RICHARDS. Oh. I understand.

Senator ROCKEFELLER. See what I mean?

Governor RICHARDS. I understand. I understand. I personally would have no objection to that at all.

Senator ROCKEFELLER. Yes. Thank you, Governor. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. Governor, I would like to join in welcoming you here.

Governor RICHARDS. Thank you, sir.

Senator CHAFEE. Nice to see you. I would refer everybody to Dr. Wilensky's testimony, which she is going to be giving, in which, on page 2, she notes that the department's Inspector General has reported exponential growth of these programs.

In 1986, only West Virginia was using donations as the State's share of Medicaid funding, and that was 5 years ago. In the ensuing 5 years, 38 States are using donation and tax programs. And then she outlines some of the cost.

I have no questions for you, Governor Richards, but I would make the following two points. I think this thing has got to be settled, and it has got to be settled quickly.

And, therefore, I would not be for a long-term moratorium. I understand that the Chairman has suggested a short-term moratorium. I am for that. You folks have just got to get this settled—you, meaning the Governors' Association.

And I understand, from your testimony and remarks in answer to a prior question, you felt this was possible. If it is not, we have got all kinds of problems around here. I understand the Chairman has gone into the budgetary difficulties that we have got.

So, my two points are: one, get it settled, and two, get it settled fast. And, in connection with that, we would give you a very brief extension, as far as I am concerned.

Governor RICHARDS. Well, Senator, the State of Texas does not have a donation system, and the Governors of all the States have agreed that a donation system is not acceptable, and they are perfectly happy to abandon that.

I mean, that has been a part of the whole negotiation. So, I do not think that is a point that is in contest at this point. And we agree with you. We would like very much to come to an agreement with the administration, and I think that we can do that.

Senator CHAFEE. I am sort of stunned by your saying that the donation system is not a problem. That is why we are——

Governor RICHARDS. No, sir. It is not in contest in the negotiations with the administration. The States have agreed to abandon any donation system.

Senator CHAFEE. How about the tax program that you have—the special taxes?

Governor RICHARDS. Well, we have——

Senator CHAFEE. Otherwise, why are we here?

Governor RICHARDS. I am sorry, Senator. I said earlier today that we assume that the Federal Government—to define the amount of money that it is going to have to put into Medicaid, is going to have to institute some kind of cap.

And that all we are asking you to do is that within those constraints of a cap, to allow us the flexibility. We do not all tax the same way, sir. We do not tax simply because of history and circumstances and the way the States developed.

There are a jillion reasons why we do not have identical taxation. In the State of Texas, we have never had a hospital tax; never had a tax that would fit in some kind of straight-jacket just like some other State.

All we are asking you for is that within the constraints of a cap, that the States be given some flexibility in the production of the tax monies necessary to match.

Senator CHAFEE. All right. Fine. Well, Mr. Chairman, I look forward to hearing Dr. Wilensky, but there is another point that I would like to stress.

And that is that, as Governor Richards has mentioned, we are dealing with individuals here, and the least we can do to disrupt the services for those individuals, the better—I am talking about the Medicaid beneficiaries. The least we can do to disrupt that, the better off we are. So, I look forward to Dr. Wilensky's testimony. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator CHAFEE. Thank you, Governor.

The CHAIRMAN. Further questions?

Senator BREAUX. Mr. Chairman, can I ask one short question?

The CHAIRMAN. Yes, of course.

Senator BREAUX. I understand the lady is representing the National Governors' Association.

Governor RICHARDS. Yes, sir.

Senator BREAUX. All right. Let me ask her. There are, I guess, not allegations, but, perhaps statements that some of the States are merely enacting a provider tax in order to use that to match the Federal payment, and giving that same exact amount back to that particular provider in that hospital. In effect, it is a sham tax in order that we just can raise the amount of the Federal contribution.

Is there any evidence, as a representative of the National Governors' Association, of how many States have that type of system whereby they are getting back exactly to those hospitals what they are paying in the provider tax? I mean, do we have instances of that happening?

Ms. PELRINE. Senator, I cannot give you an exact number. There are, in fact, some States where that has been the tax program in effect.

However, I would point out that at this stage of the negotiations between the Governors and the administration, we have agreed to a provision that defines a broad-based tax which applies equally to all providers in a class with some very, we think, positive and good public policy exceptions, so that that tax is inherently redistributive.

And we have also provided for a look-behind test so that HCFA can ensure itself that States are returning those tax revenues to providers only through enhancements in the Medicaid program.

Senator BREAUX. And that offer is on the table or being discussed with HCFA?

Ms. PELRINE. That is correct. Yes, sir.

Senator BREAUX. All right. Thank you. Thank you, Mr. Chairman.

Senator GRASSLEY. Mr. Chairman.

The CHAIRMAN. Yes. Senator Grassley.

Senator GRASSLEY. I am not going to ask any question, Mr. Chairman. I want to apologize to the Governor. I was at the Aging Committee hearing while she was testifying. But I sense an amicable attitude towards working something out.

And, as I said in my opening statement, my State does not have this sort of an arrangement. We hope that things will be worked out. So, I want to lend my support to those of my colleagues who have said that we hope that it can be worked out. I think it can be better done that way.

Governor RICHARDS. I agree.

The CHAIRMAN. All right. Thank you.

Senator ROCKEFELLER. Mr. Chairman, can I just make an observation for Governor Richards? She was not at this meeting, but about 2 weeks ago I was at a meeting of a number of Congressmen, and Democratic Governors—on health care.

And I have never seen such an outpouring—and I think my colleague would agree with me—of arrogance on the part of some of the leaders, so-to-speak, of the Congress, in terms of sort of lecturing the Governors as to what was going to happen, or what was not going to happen. The kind to attitude that drives people crazy about Washington.

I sat there and watched as eight hard-working Governors, whose life is a lot more difficult than that of any Senator, and who have to answer in very special and personal ways, really got lectured. And it was tremendously offensive to me. And I just wanted to say that.

I mean, I understand, as a former Governor, I understand this frustration that you have. Part of it is not just the rules and regulations. Part of it is the kind of presumptuous attitude that we have up here. And I apologize for that.

Governor RICHARDS. That is very nice of you, Senator. And I would not comment on that for anything in the world. [Laughter.]

The CHAIRMAN. Well, let me tell you, I sure would. And I do not share that view with my friend from West Virginia. I think we have a very great deal of respect for the problems and concerns of Governors, and we have people like Senator Chafee and Senator Rockefeller who have been through it.

Now, let me say to you, Governor, you have done an extraordinarily good job of representing the Governors of this country, and we are delighted to have you here this morning.

Governor RICHARDS. Thank you very much, Senator.

Senator CHAFEE. Mr. Chairman, could I make one brief comment?

The CHAIRMAN. Yes.

Senator CHAFEE. It is my understanding that the compromise you work out might involve locking in those who have been using donations, et cetera——

Governor RICHARDS. No, sir.

Senator CHAFEE. And freezing out others. I come from one of the few States—I do not know why they were so in-alert that they did not participate in this, but they have not jumped on the gravy train.

Now, I would be very distressed if some kind of a compromise kept everybody else out, those six States, or whoever has not jumped on, and locked in those who had, in some fashion.

Governor RICHARDS. Yes, sir.

Senator CHAFEE. So, if you could bear that in mind, Governor, I would appreciate it.

Governor RICHARDS. Yes, sir. I think you have been ill-advised, Senator.

Senator CHAFEE. And that naughty group that Senator Rockefeller was referring to, that was a group of Democrats who were jumping on the Governors, as he pointed out. [Laughter.]

The CHAIRMAN. I think this has gone far enough. [Laughter.] Thank you very much. We are delighted to have you.

Governor RICHARDS. Thank you, gentlemen. I appreciate it very much.

The CHAIRMAN. Our next witness, Hon. Robert Chambers, Speaker of the West Virginia House of Delegates. Speaker Chambers, if you would come forward, please.

Senator ROCKEFELLER. Needless to say, Mr. Chairman, I am very proud that Speaker Chambers is here.

The CHAIRMAN. Speaker Chambers, if you would proceed, please.

STATEMENT OF HON. ROBERT (CHUCK) CHAMBERS, SPEAKER OF THE WEST VIRGINIA HOUSE OF DELEGATES, HUNTINGTON, WV, ON BEHALF OF THE NATIONAL CONFERENCE OF STATE LEGISLATORS

Speaker CHAMBERS. Mr. Chairman, members of the Senate Finance Committee, my name is Chuck Chambers. I am Speaker of the West Virginia House of Delegates. I have been a State legislator for 13 years, and I have been Speaker of the West Virginia House for the past 6 years.

I am also a member of the Executive Committee of the National Conference of State Legislatures, and I am here today to comment on the administration's efforts to curtail States' use of provider-specific taxes and voluntary donation programs.

As you know, the NCSL represents the legislators of the 50 States, its commonwealths, and its territories. My testimony is based on policies adopted by the NCSL's State-Federal Assembly, the policymaking body that guides our advocacy efforts with Congress, the courts, and Federal administrative agencies.

The NCSL's policies reflect our dedication to preserving a strong Federal system of government, maintaining effective and intergovernmental programs, protecting our Nation's most vulnerable populations, and developing creative and constructive domestic initiatives.

I speak for all of my colleagues when I say it is hard to believe that we are within 45 days of the implementation of the regulations from the Department of Health and Human Services that will wreck havoc on Medicaid programs across the country, and that we have no commitment from this Congress to address the issue before it adjourns next week.

It is a critical issue. In many ways, it is as important as the additional financial assistance to the unemployed. After all, when the unemployed lose their health care benefits, many of them will ultimately depend upon Medicaid programs for access to care.

I can tell you that in our State, families which depend upon Medicaid health care programs may well be confronted with just as serious a crisis as those families whose bread-winners are out of work.

The State legislators are frustrated and troubled by the lack of progress that has been made on this issue. We are frustrated because we cannot plan. In the case of West Virginia, we are frustrated because when we do plan and we take action, the rules change.

We must assume the worst in developing our budgets for the upcoming fiscal year. We must assume that the funds will not be available and that we will have to initiate reductions and services or tax increases to fill the gaps.

With the weakness that we see across the Nation in our economy, I can tell you it will be a very difficult challenge for State legislatures to step forward next year and raise taxes dramatically to pick up the additional costs that would be forced upon us for the Medicaid program.

Likewise, it would be horrendous to consider what will happen to the programs if we have to reduce services to make up for the loss of funds.

We have many citizens that depend directly upon Medicaid for primary health care delivery, and those services will be jeopardized all across the nation. We find it particularly troubling that bureaucrats within HCFA and OMB, non-elected staff people, can re-define congressional intent through the regulatory process, effectively putting us in this situation, and getting away with it.

Senator Bentsen was right when he characterized the regulations and called for them to be withdrawn, but that did not happen. And now we need a legislative fix to this problem. We need the active involvement of the State legislatures in this process; we need the active involvement of the Congress. But we believe it is impossible to craft a reasonable compromise prior to your adjournment before Thanksgiving.

Given the time constraints and the complexity of the issues, we believe the most prudent course is a moratorium. The moratorium should be tied to a commitment to bring the principals of the affected entities together to develop a fair and equitable compromise that everyone can live with.

The current negotiations between the National Governors' Association and the administration are laudable, but too limited in scope. The Executive Branch representatives can meet and propose recommendations, but you and I know that it is the legislative branch that disposes of these recommendations.

In addition to the administration representatives and Governors, future negotiations must include State legislators, county officials, hospital, and other provider representatives, and advocates for the poor.

I would also stress that we need Congress deeply involved in this process so that if a consensus is reached, we can all be assured of quick action. All of these perspectives are important and will help create a compromise that takes every group's concerns into account.

And let me also say that unless dramatically modified, the proposals that we have seen coming from the negotiations between the National Governors' Association and HCFA will not be supported by a majority of the States.

I do not believe that they are that close to agreement, and if the agreement is close to the language that we saw last week, it will be devastating to most of the States, and certainly to West Virginia. I know that some of you on the committee are opposed to a lengthy moratorium.

We could support a shorter moratorium if it were tied directly to a commitment to convene a summit of the affected groups to develop compromised legislation for consideration by Congress early next year.

The critical thing for all of the States is to get past this January 1, 1992 drop-dead date, and work out something more reasonable that protects Medicaid beneficiaries from abrupt program reductions, or the elimination of some services.

If a short-term moratorium were to be adopted—with the understanding that a compromise delineating specific guidelines for provider tax programs would be developed—it is imperative that reasonable transition provisions and effective dates that are sensitive to the State legislative fiscal years and session dates be adopted as part of the overall compromise.

One of the major shortcomings of the proposal from the NGA and from the administration is its lack of consideration for biennial States. Seven States have biennial budgets, and it is my understanding six of those do not even have sessions scheduled in 1992.

I would also like to point out that West Virginia would not be covered by the grandfather clause provisions in the proposal, because we passed our legislation in a special session that began on September 30th.

And let me talk for a few minutes about West Virginia's situation. I have read the comments to be delivered today by the Director of HCFA, and also heard comments from others about the concern that the States are effectively using a scam to shift the burden of Medicaid funding entirely to the Federal Government.

I have to say, on behalf of the Legislatures of the country, we resent the implication. In West Virginia, we did not ask for the mandates. We did not set the rules, but we have obeyed them. And we spent a good 6 months working out a plan that was adopted in a special session that resulted from discussions with provider groups, Federal regulatory agencies, and others.

We were attempting to solve part of the health care crisis in our State. We did not look at it in isolation. We did not simply step into the Medicaid area and deal only with it. Instead, we rec-

ognized in West Virginia, because of our rural population, the inadequacy of access because of the demographics of our State, that we were having a health care crisis that required us to look at a more comprehensive solution.

And that is what we have attempted to do. And our plan to deal with Medicaid is not just an attempt to shift the burden onto the Federal Government. In fact, the precise reason for our program in West Virginia is to increase reimbursement rates to providers.

Because all across West Virginia, where we have a high number of Medicaid-eligible citizens, and many providers have to depend upon Medicaid patients to survive, we find fewer of those providers willing to go into the rural areas; fewer and fewer hospitals able to survive out in the rural part of the State. And it is primarily because of the inadequacy of our reimbursement under Medicaid.

So, our plan is aimed at trying to improve access to health care delivery in West Virginia. And it is not as though the State has not been trying.

In a very difficult economy, since 1986, West Virginia has more than doubled its general revenue appropriation to Medicaid. More than doubled. That now represents nearly 10 percent of our general revenue budget, other than the expenditures for public education.

So, it is one of the largest programs that we have in our State, and obviously it is a critical one for the people of our State.

We have been praying and begging for Federal attention and involvement. But the regulations that we have seen coming from this negotiation process heretofore, is those the answer to our prayers.

It reminds me of the missionary who goes into the jungle to try to save souls. The first day there, he is walking through a clearing, and there is a lion that comes charging at him. He looks to heaven, because he is helpless.

He looks to heaven and says, Lord, I need a miracle. Make this lion a Christian. And just at that instant, from the clear blue sky, a bolt of lightening streaks down, strikes the lion, knocking it to the ground. The lion staggers to its feet, it looks at the missionary, and then, miraculously, it looks to the heavens and speaks, Lord, bless this food I am about to eat. [Laughter.]

That is the way we feel. That is the answer that he got, and we feel like the answer that we are getting to our plea for Federal involvement is that we are going to be gobbled up.

The State legislatures all across the country are concerned about this, and we do not feel we have been a part of the process. We do not believe that our interests have been adequately represented.

We do not believe that there is an appropriate level of understanding throughout the nation about how precipitous this decision is. We will plead to the committee to support a moratorium.

We need a legislative signal that there will be a process that will involve the States, the Governors, the legislatures, the providers, and the recipients of these services. We need that assurance to come so that we can start doing the planning now.

On behalf of the membership of the National Conference of State Legislatures, I urge you to take immediate action on S. 1886, the companion bill to H.R. 3595. We look forward to working closely with you in the coming months, and we ask for that opportunity. I would be happy to answer questions.

[The prepared statement of Speaker Chambers appears in the appendix.]

Senator ROCKEFELLER. Thank you, Speaker Chambers. And I would just reiterate—in view of what you said, about the States having been left out—what I said before, and what Chairman Bentsen, who was not at that meeting, I think was surprised by. And I think the point you make is classic. We make these presumptions here about what is good for the country, and we just gather around in our little circles and pass it.

And in that it involves money going to the States—in the case of West Virginia at a rather high match rate—we just assume that it is going to be good news to the States, not understanding the horrible budget problems that West Virginia has, and has had for a number of years.

And I think you are exactly right. I know it is very frustrating for you, and I know, through Governor Caperton, and by closely following what goes on, that you are scrambling all of the time just to try and make a Medicaid match, much less trying to keep up with rules that are changed in the middle of the game.

Just one question from me, and incidentally, to all those assembled who are listening, Chuck Chambers is a superb Speaker of the House, and is just an excellent leader. We have a tradition of great speakers in our State.

Speaker CHAMBERS. Thank you, Senator.

Senator ROCKEFELLER. I passed a note to Senator Breaux from Louisiana that the current witness is a very shrewd Speaker. And you are. You are an excellent one, Chuck.

Speaker CHAMBERS. Thank you, sir.

Senator ROCKEFELLER. NGA earlier talked about the possibility of a broad-based tax. Now, we do not have that in West Virginia. It is a Medicaid provider tax program that was endorsed by the physicians, and it works well for us.

And, in fact, West Virginia, if the truth be told, really initiated this whole process under a former colleague of ours, who is living elsewhere right now. But if there were to be a broad-based tax, Speaker Chambers, is that something you think that the providers might endorse, or that you all might endorse?

Speaker CHAMBERS. Let me respond with a couple of points. First, the States are very jealous of their taxing authority, Senator, and we would likely resist too many restrictions on the States' ability to raise taxes as they see fit, and to spend the money as they see fit. So, we begin with a philosophical difference of opinion, obviously.

Secondly, with regard to the use of a broader tax in West Virginia, I believe we would be confronted with two immediate problems.

First, it would be difficult for us to discover a new tax in West Virginia that we have not already tried. We have had to make major changes in our tax structure several times, increasing taxes dramatically.

We had a State that was on the brink of fiscal collapse 3 years ago. As a result, we raised taxes significantly from both business and from individuals, generally.

It would be difficult for us to go back and do it again to raise the kind of money that we would be talking about to finance more money for Medicaid. That would be a major problem.

Secondly, as I commented awhile ago, we did not do our plan hastily. We spent a number of months working with providers, and it was difficult to convince them and other interested parties to the system, that this was a prudent approach, but we were successful.

To go back now and to advise them that despite all those efforts—intense negotiations, and discussions, and analysis that occurred over a long period of time—that all that is out the window, and that we have got to start over, I think would make it very difficult.

I do not believe that we would have the support that we had with this proposal, because their skepticism would have greatly increased by that time.

Senator ROCKEFELLER. In that you are speaking for legislatures generally——

Speaker CHAMBERS. Yes, sir.

Senator ROCKEFELLER. And in that you favor—as would I—a moratorium. Obviously, at the end of a moratorium has to come a decision or a conclusion agreed upon by both sides. What is it that you might, in your larger capacity, contemplate as being a satisfactory compromise?

Speaker CHAMBERS. Let me say, Senator, that one of the difficulties we face is that of the 50 States, there are many varieties of these programs.

And it is extremely important that we develop a process that allows us to identify the unique characteristics of each program and frankly assess them before we make judgments about what the end product ought to be. That is one of the concerns we have about the NGA proposal. We do not believe that it does address the legitimate concerns of the number of States.

Let me say that I think we also all recognize that there may well be examples of abuse on the part of the States. I believe the States are willing to look at changes and to favorably consider changes, but we have got to be part of a process that leads to an open and fair discussion about what those changes ought to be.

If we have that kind of a process, I believe that we can come up with solutions. We also need the time not only to develop this process, but to react.

In West Virginia's case, if we have a moratorium that expires on July 1 of 1992, it will be very difficult for West Virginia to be prepared to respond.

We go into our regular session in January of 1992. We probably will not know what the final result of the negotiations will be at that point. If we do not, if there is still uncertainty about the regulations, then what is the legislature going to do?

And we are a part-time legislature. Like most States, we are not in session all year long. We are in session for a specific period of time, and then it takes a special session call by our Governor to reconvene us, and that is expensive, and it is difficult, and it represents a real challenge to the ability of the States to respond quickly.

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So, what we believe we need, first of all, is a process. Secondly, we are going to need time. We are going to need the understanding of all of the parties that the States cannot respond immediately.

We cannot react, perhaps, as quickly as Congress could. We have got to have time to do it. But if that process is developed, I am confident that we can reach a consensus on where the problem areas are, and what legitimate changes ought to be contemplated in the program.

Senator ROCKEFELLER. Speaker Chambers, thank you very much. Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman. Mr. Speaker. Thank you for coming.

Let me take this occasion to tell you, if you have not noticed, in West Virginia what you have done with one of your previous Governors by sending him here. Take the time to look at this new program that HCFA just implemented, or are in the process of implementing called RBRBS—and I hate to use the acronym.

I want to recall for you and for everybody here that this is probably one of the most revolutionary things that is going to happen in medicine, and you can hear it by listening to the doctors occasionally complain about it.

I want to say that in November of 1989 when everybody else had given up, including the people on this committee that were conferees, on doing something for West Virginia, Minnesota, and a lot of places where doctors charge only what they need to charge, your junior Senator said he was not going to take no for an answer. He went in there, and on a weekend turned this whole thing around. Now have a really radical, different, and hopefully for many of us in this country, a much more sensible way of reimbursing physicians.

Because you are here I wanted to take the occasion to tell you that behind the scenes in this whole effort, you have made an incredibly valuable contribution to the way health care is going to be costed in this country, do to the work at your junior Senator.

The second thing, I really hope that this negotiation process works. Are you part of it?

Speaker CHAMBERS. Only very indirectly.

Senator DURENBERGER. Has the NCSL got somebody sitting there and——

Speaker CHAMBERS. They have been bystanders more than actual participants. They have gotten——

Senator DURENBERGER. Well, one of the problems I think we all face—is a couple of people are going to cut a deal here, and some folks who are not involved in it are not going to be involved. Have you given your proxy as the legislatures to the Governors, or how is this thing working?

Speaker CHAMBERS. No, sir. As a matter of fact, it is one of the shortcomings of the current process. I am concerned that there are very few States, perhaps not even all that many Governors who are aware of the intensity of the negotiations and how close this is coming to some kind of an agreed resolution.

The reaction that we got last week as we began calling other States was that most were not really aware, and certainly did not

have any intimate knowledge of the kind of details that the proposals contemplated.

Once that got out—and again, I am certainly not here to speak for the Governors' Association—but it is my understanding that the reaction that they received to the proposal from their constituents—from the Governors across the Nation—was relatively negative, from almost everywhere.

I know our Governor sent a very strong letter in opposition to the proposal, and until we contacted him, he was not aware that it was occurring.

Senator DURENBERGER. Well, I must tell you, I am on the Highway Conference, and it is just members of Congress and members of the Senate. We are sitting there trying to figure out how much bread, and butter, and pork we are going to take home to our home States, and trying to divide up a limited pie. That is very difficult to do.

I am just concerned about this moratoria, and putting off, and putting off. We have 50 legislatures; we have 50 Governors. I do not know we have involved the counties in this. A lot of our public health institutions are provided by counties.

I just must reflect the concern here, Mr. Chairman, and others, that we can talk about putting this thing off all we want. But, until some people around this table, or some people at the witness chair get involved and decide that by a certain deadline, there is going to be an answer to this problem. This thing is going to go on forever.

Speaker CHAMBERS. Senator, we first concur that the plan does need immediate attention. We do have a crisis and it needs to have a response. What is more important though, than a quick response is to be thorough about what we are doing.

And that is why I stress that I think it is most important to proceed with the moratorium legislation so that we know that nothing will happen immediately, but that also there is a process that will be developed and begin now to require all of the participants to come together to shape a solution.

I am convinced that you have gotten the attention of the States. The SSL is ready and prepared to be a part of this negotiation process. Other representatives of other constituencies are here today. I am sure they will all tell you the same thing. We need the time do develop it, however.

Senator DURENBERGER. Well, Mr. Chairman, let me just reflect another concern, and trying to stay with the realities here that this committee and the Senate and the Congress, you said, it is hard to find a tax we have not already tried. You know, I think we are all in that same boat. We are not taxing anymore. We are sending the bill for every adjustment we make here—and for everything you do in the West Virginia Legislature that adds taxes to Medicaid and then sends the bill to us is not going to the taxpayer. It is going to our children in the form of a deficit. The Governor of Texas pointed that out. This is no game we are playing.

This is no game where somebody runs out and says, we are going to increase hospital taxes by $700 million in Texas, or $500 million in Minnesota.

You have to remember where this money is coming from. It is not coming from current taxpayers. It is coming from folks who use hospitals and all the folks who have third-party payment systems are going to pay that tax. It is the little revolving fund. You know, there are a lot of people that do not know they are being eaten by the lion, or the missionary, or whoever it is being eaten by it. We spin this little game around and send the bill off to our kids.

What I have a bit of a difficulty with, particularly for those of us who are accused of causing these problems with Medicare, is that you are causing those problems.

You people are paying about 46 cents on the dollar for hospital charges because it is easier to say no to the Medicaid person in the hospital than it is to say no to some other stronger interest in your State. We know that to be the case.

I am not accusing you of anything. That is the way the game is played. But you are down—you legislatures are down to about 46 cents on the dollar of charges, and about 65 or 70 cents on actual costs in these hospitals.

So now, instead of raising the taxes, or doing whatever you have to do, lowering the fees, or whatever those things are, we are into a cow milking contest.

Having said that, I go back to where I was in the beginning. This system is broken and needs to get fixed.

The relationship needs to get healed in some appropriate fashion, but this is not the way to do it. The way the legislatures have been going in the last 12 months is not the way to heal it.

So, I just hope you use your influence through the Conference of State Legislatures on the Governors, or whoever is at the table, to get us a resolution by the end of this week, if that is at all possible.

The CHAIRMAN. Gentlemen, we have Dr. Wilensky here, and a panel of very distinguished witnesses, if you would keep that in mind. Senator Grassley.

Senator GRASSLEY. All right. Mr. Chairman, I will not take more than my allotted time; maybe not all of it. Mr. Chambers, I do not take exception to what you said about being offended about people calling some of these methods scams.

That comes from the feeling that we do not really get any new revenue into health care by the way some of these systems might work. Now, are you saying it does not happen in West Virginia, or it does not happen in any of the States, or you are offended if it does happen in some States?

Speaker CHAMBERS. Let me respond first, Senator, by saying that in West Virginia's case, we have raised general revenue tax appropriations to Medicaid by—well, we have doubled them over the last 5 years to meet the additional mandates, to meet the additional demand for services because of increased numbers of people being served by Medicaid.

So, we really feel like we have come a long way in a relatively short period of time in a very difficult economy to fulfill our obligation. What we still experience, though, is a loss of providers throughout the rural parts of the State because the Medicaid reimbursement rates in West Virginia are among the lowest.

Frankly, we do not have the ability to go into other areas to carve out money to increase Medicaid funding to thereby increase

reimbursement rates. So, we relied upon the provisions of the statutes and the regulations as they previously existed to develop our provider tax.

And after several months of discussions and negotiations, we imposed it in a special session. The purpose of it is to increase reimbursement rates, which we believe is going to help us sole an immediate crisis for health care delivery in the rural part of our State.

And let me comment here, that to me, that is the bottom line for our State. If this whole program is in jeopardy, if we lose it, if we have to redo it, if there is an interruption in services, the State legislators are going to complain because of what we face, but it is going to be the people in rural West Virginia that are going to suffer because they are going to lose health care providers, they are going to lose access for health care delivery.

Senator GRASSLEY. But you are not saying that this might not be the case in some of the States?

Speaker CHAMBERS. It could be. I cannot speak to the experience of all the States.

Senator GRASSLEY. All right. Then the other—just comment from you, more than a question. There is a feeling that really the end result of this is that people kind of want to end what started out as a Federal/State partnership, and that this is a back-door way of doing it, and that if there is something wrong with the Medicaid program, why do we not just reconfigure it up front with positive legislation and do that here at the Federal level in conjunction with the States?

Speaker CHAMBERS. Absolutely. I think that is the role that the Congress ought to play in taking the lead to help us do that. We do not want this to be a short-term resolution that will lead to problems in the future.

Senator GRASSLEY. Well, then in a sense you are saying that this is a way of forcing reconfiguration from a Federal/State partnership to more of a Federal role in the Medicaid program.

Speaker CHAMBERS. Yes, sir.

Senator GRASSLEY. And you think that should be done?

Speaker CHAMBERS. I think it could be done. The States obviously would have some concerns, but I think those could be addressed. We would like the opportunity to work with the Federal agencies and with the Congress to fashion that sort of solution. It would be a long-term solution.

Senator GRASSLEY. Well, the end result of that is that you are really pushing the costs up to the Federal Government, whether it is legislated, or whether we do it through this back door way. If that is what the States are trying to do, then I think that they ought to say that is what they are trying to do. I am done, Mr. Chairman.

The CHAIRMAN. Thank you. Senator Breaux.

Senator BREAUX. Thank you very much, Representative Chambers. Glad to have you here. I am delighted with your presentation. Let me just ask a question. I get the impression that some are concerned in HCFA that some States are enacting these provider taxes just in order to say, all right, we are going to give it right back to

you; just loan it to us for awhile so we can raise up the match that we are entitled to get from the Federal Government.

And that they are levying these taxes, not based on Medicaid service, or maybe just on Medicaid services, and saying, all right, we are going to tax you, hospital, $100, and we will use that $100 to get the money from the Federal Government. And then we are going to guarantee your $100 back directly.

How does the West Virginia program work so that that does not occur?

Speaker CHAMBERS. Well, first, the legislation we passed actually does not take effect until January 1, 1992, which is another one of our concerns. The program has been adopted, regulations have been developed. But the plan itself actually does not begin until this January.

Through the mechanism of the provider tax, we would be generating enough money that we would be able to increase our reimbursement rates significantly. We do not intend, and we have made express representations to this effect—to reduce the State's current funding for Medicaid. We have increased it dramatically over the last several years.

That is part of the commitment that the State made; that we will continue to do that. And we are not going to try to use this provider tax to reduce the State's share from its more traditional general revenue source for its Medicaid program.

Senator BREAUX. So, I guess that is how, but how would you respond to those that say some States have enacted what, in effect, is a sham tax?

Speaker CHAMBERS. Well, in two ways. First, if that is an appropriate characterization for the plans, then we need an opportunity for the States to be involved in a process that gives us time to make the change.

Because frankly, if these were scam programs, they were nonetheless legal. And we relied upon the statutes and the regulations in effect when the States took this action.

So, if it really is a fair characterization to call them a scam, then, remember, we did not set the rules in the first place, but we did rely upon them, and we ought to be given an adequate opportunity to decide what will replace that structure and then have time to take appropriate action to see to it that it is positively addressed.

Senator BREAUX. When does your legislature meet again?

Speaker CHAMBERS. We go into a 60-day regular session in January.

Senator BREAUX. All right. Thank you. Thank you, Mr. Speaker. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. Senator Rockefeller.

Senator ROCKEFELLER. I already asked my questions, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Speaker CHAMBERS. Thank you.

The CHAIRMAN. Pleased to have you. Dr. Wilensky, if you would come forward, please. Dr. Wilensky, we are very pleased to have you. You are at the fulcrum of this concern and what is taking place. I would be particularly interested, and I know the committee would be, in your report about current negotiations. I know there

are some intense negotiations, apparently, between you, and OMB and the administration and the Governors over the last few days. And if we are any closer to a compromise or solution, I would be pleased to hear it. It seems we are faced with a concern here, if we could get it done now, that would certainly be our preference.

Otherwise, I am interested in possibly having a short—and I mean short—moratorium to see that it is worked out, but one that would be of a period of time that would keep the pressure on all sides to try to resolve it, because obviously we have here a situation that really tears the system apart, and I want to see it resolved if we can. If you would go ahead.

STATEMENT OF HON. GAIL R. WILENSKY, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Dr. WILENSKY. Mr. Chairman and members of the subcommittee, I am pleased to be here this morning to discuss with you State donation and provider tax programs.

As one of the two key programs in meeting the health care needs of our Nation's most vulnerable citizens, Medicaid must remain strong and stable to ensure that the poor receive essential health services.

Let me say this as straight as I know how. Absent restraint, State donation and tax programs could destroy the Medicaid program by undermining the basic premise that funding be shared through a Federal match of State monies.

In a matching program, those responsible for the States' direct fiscal management must have a reasonable stake in costs. This is what the whole program is premised on. State matching requirements have always acted as a critical restraint on the otherwise open-ended Medicaid program. Provider donation and tax programs represent a potentially huge Federal budget increase.

Federal Medicaid obligations increased 17 percent from 1989 to 1990, and 31 percent increase is projected for 1991. In 1986, only West Virginia was using donations as the State's share of Medicaid funding. Now, some 45 States have, or are working on such programs.

Our Inspector General reported the following exponential growth in Federal matching fund requests from these programs: $1.5 billion in October 1990, $2.5 billion in May of 1991, $3.8 billion by July 1991, and we estimate at least $5.5 billion for fiscal year 1992.

We believe that some States are using these "free Federal funds" to increase services, expand access, and make other positive changes. But there is nothing in the current situation that allows us to ensure that these new Federal funds are used in this manner.

In fact, the Inspector General reported that generally these programs are not being used to increase services or improve the quality of care, but rather are being substituted for existing State monies.

Donation and tax programs vary from State to State, but they tend to alter the matching rate in basically the same way. Typically, the States borrow money from providers through donation or tax programs.

The money is used as the State's share of Medicaid and is matched at least dollar for dollar by Federal funds. States frequently increase Medicaid payments to reimburse providers for the donations or taxes they are paid.

And, in many States, the providers are guaranteed to get back at least as much as they have donated or paid into the provider-specific taxes through the hold harmless mechanisms.

I have here an example to show you. In year one, the hospitals were being paid $100 million under Medicaid on this first line.

Assuming a Federal match rate of 50 percent—the lowest match rate that we have—the State and the Federal Government would each pay $50 million.

In year two, the State both implements a donation and/or a tax program, and receives $50 million in contributions from the hospitals, and increases the nominal payment to the hospitals to some $200 million. That is shown here in terms of this nominal contribution.

The hospitals actually receive the same net payment of $100 million after deducting the cost of the donation or the tax. Now, however, the $100 million is 100 percent federally funded. Before the financing strategy was used, the State paid 50 percent of the provider payment. But now the State would pay nothing for this incremental amount.

In this example, the Federal matching rate goes from a nominal 50 percent to an effective 100 percent. This is just one example.

In other examples, new dollars—all Federal—go to the providers. In others, the State adds coverage with the funds it makes available. Lest you think that I am being extreme, let me give you an example of a case that occurred in the State of Pennsylvania.

Pennsylvania lost a Boren Amendment case, and was forced to increase the rates that it was paying to hospitals. Rather than put in new State monies, they had 170 hospitals form together and become a foundation. This foundation then borrowed funds from a lending institution, some $360 million, and gave the $360 million to the State of Pennsylvania, for which they received a Federal match of $385 million. Pennsylvania is about a 55 percent match State.

The State then sent back the $360 million that the hospitals—now this group—had given to the State, to the hospitals through increased disproportionate share payments. The hospitals repaid the foundation, which repaid the lending institution.

The $380 million of Federal funds went to hospitals that were providing services so that they could have an increased payment rate. This is no great trick to figure out what happened. The only new money in the system was our money.

This was a case where we clearly had a substantial increase in the effective match rate, not because of something that you did, and not because of something that we did, but purely because of something that the State of Pennsylvania did. This is not, by any means, the lone example. It is just crystal clear what was going on.

We should not allow this fundamental change in Medicaid without full and open policy discussions on all issues, including financing any changes that we may wish to have.

In November of 1990, the enactment of OBRA–90 continued a moratorium on issuing final donations regulations until January 1, 1992. OBRA–90 also prohibits matching funds when States reimburse providers for costs attributable to taxes imposed solely on them.

Provider-specific taxes which are not linked to Medicaid institutional payments will still be eligible for full Federal financial participation. Following a September 12, 1991 interim final rule that caused some confusion, HCFA issued a clarification on October 31.

We are not eliminating the use of all inter-governmental transfers. Legitimate public funds transferred between local governments will continue to be allowed under the current law.

One example of a legitimate inter-governmental transfer might be where States require county property taxes to be contributed to the Medicaid program. These funds would be matched with Federal dollars, so long as the taxes are not provider-specific and are not linked to Medicaid payments. County-generated taxes and donations will be bound by the same rules as State-generated taxes and donations for Federal matching purposes. This rule defines the amount of provider-specific tax payments not allowed for Federal matching.

The matching that is to be withheld is the lesser of the providers' entire provider-specific tax payment, or the portion of the Medicaid payment to the provider that can be attributed to the tax payment. We believe this interpretation reflects the best reading of an admittedly confusing OBRA–90 language.

The October rule provides a delayed effective date of July 1, 1991, provided that States submit an application by January 1, describing the changes that they will make to their donation and tax programs to achieve compliance with the rule, and provided that they enter into an agreement with HCFA to implement such changes no later than July 1, 1992.

We are working with any State that wishes to discuss their unique problems and to explore reasonable means by which they can transition into acceptable funding arrangements.

We know that our rulemaking is controversial, but we believe it is consistent with the OBRA–90 statute. However, because of the potentially disruptive nature of the rule; the difficulty States face in trying to balance their budgets; the dispute over the interpretation of the OBRA–90 statutory language; and the complicated technical and administrative issues involved in interpreting the rule, we believe a legislative change is preferable to the rulemaking effort.

We have been working with the National Governors' Association as part of our efforts to develop such legislative options.

Let me give you some sense about where we are in this, although I know that you have heard about this earlier in the morning. We have been trying to craft a proposal that both the Governors and the administration would feel comfortable with.

The broad scope of what we have been working on includes the following: the use of provider donations for purposes of Federal match would not be allowed after January 1st of 1992. Donations from charitable organizations, of course, would continue to be allowable.

Limited donations for out-stationed eligibility workers would also be allowed. Provider taxes for Federal matching purposes would be allowable if the State uniformly levies the tax on all providers and on all of their business, with no hold harmless agreements that guarantee a return in whole or in part to the provider.

Total State revenues for matchable provider taxes would not be able to exceed a specified percentage of the State's share of Medicaid. States that are above this threshold would have 3 years to transition down to the level. There are not very many States that would be above that level, however.

We believe that the compromise does not affect those who are currently using inter-governmental transfers for Medicaid funding; they may continue to use these arrangements.

Disproportionate share hospital payments would be impacted. In particular, the aggregate pool of disproportionate share payments in any State could not exceed a certain percentage of the State's total Medicaid expenditures, and the payments would be pegged to Medicaid and low-income utilization rates, but with substantial modifications for State flexibility.

Finally, the effective date of the tax provisions would range from July 1st of 1992 to October 1, depending on the State's legislative calendar.

Let me also just briefly mention the bill that is on the House floor today to extend the moratorium through September 30, 1992 on the issuance of any regulation changing the treatment of voluntary contributions or provider-specific taxes.

If this legislation is enacted, we will return to a situation that allows existing donation programs to continue and give States unrestrained ability to obtain Federal matching funds using provider-specific tax programs.

There is no question in my mind that this will make this very large problem which we now face much, much worse. The more States rely on these programs, the more difficult it will able to transition off these funding mechanisms.

As this year's experience has shown us, an open-ended moratorium will allow States to aggressively pursue such funding mechanisms, and dare anyone to take them away. We do not want the current problem to be even worse next year. We are overwhelmed by the amount of changes that have occurred during this current year.

A legislative solution is needed to set clear boundaries for States, and to give HCFA administrative flexibility to address the difficulties that the issue has posed.

States will need to remain accountable for the appropriate management and financing of their programs, and the Federal Government is responsible for holding them accountable.

I do not know whether we will be able to work out an agreement such as I have described at a programmatic level. We have been doing our best for the past 2½ weeks to accomplish this. We understand that the time is growing short, and there still are some problems that have been raised.

But it is in this vein that I and others in the administration are more than willing to discuss the ideas we have been working on with the NGA, or to discuss with members, with their staffs, or any

other responsible parties, any other ideas that you think would be appropriate to protect the integrity of the Medicaid program. But we are very concerned about the very limited amount of time we have left. I would be pleased to answer any questions that you may have.

Senator BREAUX. Thank you very much, Dr. Wilensky. What is the status of the negotiations?

Dr. WILENSKY. We are waiting to hear from them on a specific counter offer, if they wish to make some comment. At the last time we spoke, which was late yesterday, it did not appear as of that moment that an agreement was imminent, but we did agree to continue discussions.

We would like the Governors to indicate if what we have been discussing is not acceptable—and we know there have been a number of discussions in the last week with individual Governors, as well as the Executive Committee—to give us very specifically what they would need to see changed.

Senator BREAUX. I take it that you prefer a legislative fix, rather than the regulatory process if an agreement can be arrived at.

Dr. WILENSKY. I would strongly prefer a legislative fix. I think it allows us much greater flexibility in how we can structure an arrangement that both protects the Federal budget, and also gives States additional flexibility.

Through the regulatory mechanism, we are tied by the words of the OBRA–90 statute, or previous statutes, and there are things that we would like to do that we cannot.

Senator BREAUX. What is wrong, in general, with a State that is faced with a match, they have to contribute to participate in a Federal program, from levying a tax on those that receive the benefit of that program?

I mean, what we are talking about is some States have said, all right, the hospitals are going to benefit from the Medicaid funding. Therefore, they are going to have to pay the 25 percent; that is the State's match. What is wrong with that?

Dr. WILENSKY. Well, there is something fundamentally amiss, and we have been trying to figure out if it ever occurs in any other program, where the direct recipients of the money are asked to put up some money have that enhanced and then have those amounts go back directly to them. We think it is a difficult arrangement either with a direct hold harmless, or with an effective hold harmless. That is, the money is returned to the hospitals that put it up by guarantee or, in fact, by outcome.

We are less concerned with a broad-based provider-specific tax—that is, a tax on all the hospitals in a class, on all their revenue—because we think that, by its nature, will result in redistribution from some institutions to others that happen to be providing services to the Medicaid population.

The nature of Medicaid is that relatively smaller numbers of providers provide services to significant populations. Typically, substantial numbers of hospitals or other providers provide very little, or no services.

It is the return to the people who put the money up, with an enhancement, that tends to give you a distorted financial picture and leads to the kind of abuses that I was speaking of.

Senator BREAUX. I think we have examples in other Federal programs. I was thinking of many of the Corps of Engineer projects that are based on a matching basis that, in fact, levy taxes on the beneficiaries of that particular project.

What is the incentive for a hospital, for instance, that does not treat any Medicaid patients, to support a tax which would contribute to a fund in which they would never participate in?

Dr. WILENSKY. We want the natural tension that is supposed to exist in the tax program to exist. You can ask, what is the reason for a State to be willing to use general funds, or a sales tax, or a property tax.

The notion is that it is supposed to involve some redistribution. To the extent that you are just returning money to the institution that put it up, with some augmented amounts of money, that really is not putting new State dollars into the system. I mean, the new dollars are coming only from the Federal Government.

I think this may be true with your Engineering Corps example, although I admit I do not know it as well as I know others. In the highway tax, it is not the contractor—it is not the people who build the highways—that put up the money.

That would be the best analogy to the hospitals that will directly receive the money, not the services. It is the Medicaid recipients who receive the services. But it is the hospital which will directly receive the funds that is being asked to put up the funds.

It is like asking the highway contractor—the group that is going to build the roads—to donate money, or to tax themselves to put money up so that they can get additional highway tax money.

I do not think there really is a very good analogy to that. And it leads to the kind of abusive situations that we have found. We have felt that the nature of broad-based provider taxes will force redistribution. We want that very redistribution you just mentioned.

Senator BREAUX. Let me ask just one final question. What is the role, if any, that the disproportionate share hospitals play in this discussion on the Medicaid reimbursement situation?

Dr. WILENSKY. Well, what has happened now because of this funny money funding is that disproportionate share hospitals have tended to be the outflow where the money comes back to the State, because there are no upper limits to the disproportionate share payments. As I am sure you are aware, originally, the purpose was to give hospitals that provide a lot of care to low-income or Medicaid people a way to get funding above the regular Medicaid level. Until there was funny funding, the fact that there was not an upper payment limit was never really a problem.

The natural restraint of having a State to use its own tax money served as the kind of restraint that needed to be in place. It is only when it is paid with full Federal funding that this disproportionate share payment takes on a whole new role that I believe that Congress never intended it to play, frequently having very little to do with low-income or Medicaid populations.

Again, the example in Pennsylvania is so clear that I think it makes very obvious that particular routing of disproportionate share funding had nothing to do with disproportionate share.

Senator BREAUX. Your solution to that is to propose, what, some standards on how many hospitals—or what percentage of Medicaid patients they service?

Dr. WILENSKY. In attempting to reach an agreement with the Governors, we have been willing to say that the States could maintain maximum flexibility in the designation of disproportionate share hospitals. We wanted, however, to have some assurance that the total amount of money had some limit.

We have looked at disproportionate share spending over the last few years where it has been growing exponentially; truly at an astounding rate. It represented 3 or 4 percent of funding a couple of years ago, 7 percent of Medicaid expenditures last year, and it is in the neighborhood of 11 or 12 percent this year.

The requests for donation and tax programs are coming in so fast we are having trouble figuring out what they are representing and how much money is involved. What has happened in the last 2 or 3 months is really beyond belief in terms of requests coming in from the Governors and the States.

Senator BREAUX. Thank you, Gail. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, thank you. Gail, Senator Breaux asked you about who benefits from this program and I think we understand that leaving aside the public benefit—which no one is willing to tax in order to deal with—the realities are the principal beneficiaries are institutions that deliver health care; hospitals and nursing homes, for example.

The way it worked in my State as we worked up to 1991, is over a period of time, the reimbursement payments for Medicaid to nursing homes and hospitals kept declining as a proportion.

Their costs were going up, their payments stayed fixed and so there is a wide disparity. So everybody gets desperate. I mean, how do I run my hospital? How do I run my nursing home?

Well, some politician comes to them and says, tell you what I will do. You give me a dollar, let me keep it for 30 days, 60 days, 90 days, something like that. I will go milk the Federal Government for $2.00, or up to $2.50, I suppose, in Mississippi, and I will give you your dollar back.

Dr. WILENSKY. Four.

Senator DURENBERGER. Or whatever. You get how many dollars back?

Dr. WILENSKY. Four. Four to one is the highest match.

Senator DURENBERGER. Four to one. So, that is basically——

Dr. WILENSKY. You have got it.

Senator DURENBERGER. That is the prostitution in the system, and nobody likes it. The hospitals do not like this, nursing homes do not like it; nobody likes to play prostitute in this system. But basically, that is the egregious—as I understand it—part of this system.

Now, let us back away from that and assume that Governors, legislators, Congressmen, and Senators do not like that kind of a system anymore than the hospital or the nursing homes do.

I wonder if you can deal with something I know the Children's Defense Fund and others will deal with later in the testimony? And that is, what is wrong with provider taxes? What is wrong with

continuing the great old American notion that, them what can pay, pays more than them that can't pay?

This business of taxing the revenues of hospitals or nursing homes in some way, is that not simply a continuation of the old system of, if you cannot pay, your bill gets added to the Blue Cross bill, or whatever it is, of somebody who does pay.

Is this not just another form of doing that? And in the negotiations, you are trying to limit the amount of the Medicaid dollars that can be, in effect, shifted onto other third party payors. Why?

Dr. WILENSKY. Well, you have posed several questions. Let me try to break them apart quickly. Cost shifting is becoming increasingly more difficult to do.

When we were not focusing as payors on trying to get the best buy that we can for our money—and that characterizes the 1970's much more so than the 1980's or 1990's—we tolerated cost shifting as a way to finance a lot of the uninsured and some portions, perhaps, of Medicaid as well.

It is becoming increasingly difficult for hospitals to shift costs when payors insist on only paying their share, as well they should, if, in fact, you want to contain health care costs. It is hard to contain health care costs in an era of cost-shifting.

But the problem is that while we prefer really broad taxes on property, or income, or sales taxes, we acknowledge that States are finding it difficult to raise new revenues, and they feel that there are some sources they have not traditionally tapped.

While you could argue that these may or may not be the best taxes, they have not been used before. Our concern is to make sure that new taxes really represent new funding in the system.

To the extent that the tax is on the disproportionate share hospitals—the hospitals that we always hear are hurting so much—the notion that they put up money that gets matched and then sent back just does not make any sense on the face of it.

If, in fact, you want a redistribution from those hospitals that do very little Medicaid to those who do a lot—which would happen in a broad-based tax where there is no hold harmless to the people who contributed but do not provide Medicaid services—that is all right. Maybe not as good as a really broad-based tax, but at least it gets around just returning money that has been loaned for purposes of matching.

There is no question that when you have these very highly leveraged States—the 4:1 match or the 3:1 match—it is easy to have money returned if they provide any amount of Medicaid services at all.

We recognize it is a problem, and it is one of the reasons we have wanted to put a limit on how much of the States' share of Medicare funding ought to come from provider-specific taxes.

We do not think it is wonderful, but we think it is at least tolerable, because it does not just put money up and return it to the source that it came from. At least there is some redistribution.

Senator DURENBERGER. Thank you. Just to make the last observation—at least I read this recently, the AFL–CIO, for one, representing taxpayers and health insurance payers in this country, has awakened to the fact that this cost-shift is going on.

They now characterize it as a sick tax, and so any State legislator, Senator, or whoever is going to participate in one of these schemes of loading taxes on hospitals, nursing homes, or whatever it is, is going to hear from some other health insurance payors who see their rates are being raised by reason of this shift. This is only by way of saying we are dealing with what appears to be an intractable problem.

But, I think the taxpayers could help us resolve it, if, in fact, we could let them see where the pea was under the shell, but we keep moving the shells around all the time. Nobody knows where it is, and it makes it very difficult to deal with the underlying problem, which is the cost of care.

Senator BREAUX. Senator Grassley.

Senator GRASSLEY. Yes. I was out when you answered for Senator Breaux, but it is my understanding that such a negotiated agreement would require legislation. Are you in a position to tell us what would be the cost of that legislation?

Dr. WILENSKY. That is something that I would be glad to provide you in writing from the Office of Management and Budget. They do the official scoring of any new legislation. We are obviously mindful of that as we go ahead.

[The information appears in the appendix.]

Senator GRASSLEY. All right. As you know, there is a great deal of concern on the part of many of those who work with low-income people, or advocate on their behalf that denial of the funds raised by these methods that we are here to find out more about, and as are proposed in the regulation, is going to create a great hardship in many States—particularly in those which are having budget difficulties of their own.

How do you respond to the question as it relates just to programs for lower income people?

Dr. WILENSKY. The Congress and the administration have agreed on a matching relationship, based on per capita income in States, that ranges from a 50-percent match, to an 83-percent match.

If the Congress thinks that is not appropriate, that it is not big enough, that it is not wide enough, or that we need to do more for poorer States, then that is a fair question to put on the table. We cannot have what is going on now. It is not the poverty level of the States. Nor how much they are spending on Medicaid that determines their effective match rate anymore; it is how aggressive they have been at going after this new, 100 percent Federal money.

Sometimes it is very poor States that have been involved, like Alabama and Tennessee, but sometimes it is not particularly our poorer States that have been very aggressive.

Any sense of control goes out the window when we have none of the normal cost constraints that we put in place for a fully Federal program. But we still have full Federal funding.

We understand that timing is an issue, and that is why in the regulation, or, in fact, in talking about legislation, we recognize it would take States until July or October, depending on their fiscal years, to change their programs.

We want a transition. We want to give them time. And for those that are over the limits, we want to either hold them harmless, or transition them down slowly. So, we are trying to recognize timing

is a problem. Now, I understand for a State that has used full Federal funding for its incremental Medicaid dollars, anything less is going to hurt. But unless the Congress wants to switch to full Federal funding of the Medicaid program, they have got to stop the current trend and start moving back to traditions matching relationships.

I do not think anybody saw this coming, and it has happened so fast in the last year that it is really making our heads swim.

Last October, a year ago, this was a $400 million problem.

Right now, we think this is a $5.5 billion problem in this next fiscal year. If the Waxman moratorium goes into effect, we assume we could be talking about a $10 or $12 billion problem a year from now. There is no limit on how big this thing can get.

Senator GRASSLEY. My last question, I think, refers to that $5.5 billion and what that figure was. Is that a pretty certain figure that we are dealing with?

Dr. WILENSKY. Well, what is certain is it was $4 billion as of October, and our actuaries estimate for fiscal year 1992 that it will be $5.5 billion. And that, clearly, is an estimate. What we saw was a jump from $400 million in October to $4 billion by late summer this year; less than a year's time. That is a pretty astounding growth.

Senator GRASSLEY. Thank you, Mr. Chairman.

Senator BREAUX. Dr. Wilensky, let me ask you one other question. My State of Louisiana has been providing hospital services to low-income patients for about a half a century; long before we had Medicare, Medicaid, or any of the programs we now have. In addition, we do not have a provider tax in Louisiana.

So, I guess what I want to ask is how would the proposed regulations affect a State that is obviously not using a disproportionate share program to offset provider taxes, because we do not even have one.

Dr. WILENSKY. Under the regulations that we have put out, there is one disproportionate share piece. There is another one that will come if the legislative route falls apart. The one that is published allows a State to designate only the hospitals that are above the mean in terms of serving low-income and Medicaid patients.

What we found is that there were some States—because the provider taxes tended to be funneled back to disproportionate share hospitals—that were designating almost all, or all of their hospitals as disproportionate share hospitals to allow them to pay them in different ways.

The second thing is that under a regulation that has not yet been issued, but will be if we go forward with the regulatory strategy, we will have some limits in the differences that can exist in disproportionate share payments.

I do not know enough of the specifics about how the disproportionate share payments are made in Louisiana. If there are not wide numbers of hospitals being designated—and I do not believe that there are; I do not believe I have ever seen Louisiana on our lists of hospitals we thought were at risk—and if the relationship in payment between different disproportionate share hospitals is in some reasoned relationship to each other, it would not be affected under the regulations.

Under the legislation we have been talking about, there would only be the overall cap. To the best of my knowledge, Louisiana was not affected. But we can give you more specific information if you would like that.

Senator BREAUX. Well, our system is a little unique, obviously, in the sense of a charity hospital type of system we have had for 50 years.

Dr. WILENSKY. Right.

Senator BREAUX. And obviously they were not set up in order to increase Medicaid reimbursements, because we did not even have that type of program.

One other question that I have been asked to put to you is that are these new regulations really telling States how to tax, who to tax, when to tax, how much to tax? I mean, are we not interfering in the States' flexibility and ability to be their own taxing authority?

Dr. WILENSKY. We are distinctly not telling States how they can tax. We are saying what we will recognize as funds for purposes of matching. Since we are on the other side of those dollars, I think it is reasonable. The fact is, States can tax any way they wish. But when they come for Federal dollars, they have to meet certain regulations.

Senator BREAUX. All right. We thank you. We may have some additional questions to submit. We hope that you would respond to them promptly. Thank you very much.

Dr. WILENSKY. You are very welcome.

[The questions appear in the appendix.]

Senator BREAUX. Let me invite up the next panel. Please, let us have order in the committee hearing room.

Mr. Richard Dixon, chief administrative officer, County of Los Angeles; Dr. Randall O'Donnell, chief executive officer of Arkansas Children Hospital; Ms. Sara Rosenbaum, director of the Children's Defense Fund; Ms. Lucy Yates Shaw, who is president and chief executive officer of the Regional Medical Center in Memphis, on behalf of the National Association of Public Hospitals. Gentlemen and ladies, we have Mr. Dixon listed first.

Mr. Dixon, if you would like to proceed, we would be pleased to receive your testimony.

STATEMENT OF RICHARD DIXON, CHIEF ADMINISTRATIVE OFFICER, COUNTY OF LOS ANGELES, LOS ANGELES, CA, ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES

Mr. DIXON. Good morning, Mr. Chairman. I am Richard Dixon. I am the chief administrative officer of the County of Los Angeles in California and the president of the Government Finance Officers' Association.

This morning I am speaking for the County of Los Angeles, and the National Association of Counties, but, perhaps more importantly, for the tens of millions of people in this Nation desperately in need of maintenance of our current health access, and, indeed improvement of our current health access.

I would ask the committee's permission to file with you my written statement and make brief comments in addition.

Senator BREAUX. Without objection that will be ordered, and I would urge all of our panel members to follow that example. Thank you.

[The prepared statement of Mr. Dixon appears in the appendix.]

Mr. DIXON. Thank you, Mr. Chairman. In my county of nearly 10 million people on the Pacific Rim, 2.7 million of those people are currently medically uninsured.

More importantly, though, than even that number is the fact that the maintenance of reasonable health access in the county hospital system of my county is critical to the emergency medical care of every resident and every visitor to Los Angeles County.

In the last 4 years, 10 of the 23 designated trauma centers in my county have closed, essentially for financial reasons. Los Angeles County's six county hospitals currently provide over half of all the trauma center care in the county.

Our current fiscal year—we operate on a July 1 to June 30 fiscal year—anticipates slightly in excess of $300 million of revenue from the newly adopted California inter-governmental transfer Medicaid program. It is absolutely crucial to the maintenance of what we all refer to as the "safety net."

In my county—and I submit to you in many hundreds of other counties across this country—it is crucial that we have a moratorium so that a carefully thought out, flexible, reasonable compromise can be reached. I certainly appreciated Senator Durenberger's observation that this is not only a matter for the Governors. It is also, as the esteemed speaker from West Virginia said, a matter for the State legislators. As Senator Durenberger noted, counties are also concerned. Throughout this Nation more than 30 of the States share, or, indeed, substantially give to or foist upon the county government the legal responsibility to care for indigents in their health system.

In the Los Angeles county hospital system, we are impacted not only by the mandates the Federal Government has placed on the State and the State has shared with us in the area of direct health care, but we are heavily impacted by the failure of the Federal Government to control the border south of my county.

Let me give you some idea of the impact. In the last 10 years, the overall admission to my health care system of hospitals of inpatients has risen 31 percent, while the births in my county hospitals—over two-thirds of which are to undocumented, foreign-born mothers—has risen 131 percent. We are impacted by Federal actions. We need fair and reasonable Federal support. The State of California currently has 14 percent of the Medicaid recipients of the Nation. And even with our new Inter-Governmental Transfer Act, the State will be receiving slightly less than 10.5 percent of the Federal Medicaid dollars.

My Governor and your former colleague, Pete Wilson, is gravely concerned about the possible imposition of arbitrary caps and unnecessary restrictions.

If we are to have mandates in the health care area—States and counties must also have, as you have heard this morning from able representatives of those governments—flexibility in how they cope with it.

The Medicaid problems of this country, the health care problems of this country, are not simple; they are complex. We are a nation of 50 separate sovereign States, and each of you represent a different one of those States. Within those States we have hundreds of separate counties, each coping with this problem in their own best way.

As you have heard from the State representatives, flexibility is important. If, as you hear from OMB and HCFA, there are problems with the system, we need to work it out in a reasonable period of time with a reasonable moratorium.

I urge your committee to pass a moratorium act so that a reasonable compromise can be reached which would minimize human suffering. Thank you, Mr. Chairman.

Senator BREAUX. Thank you, Mr. Dixon. Next, from the State of Arkansas, Dr. O'Donnell.

Senator PRYOR. Mr. Chairman, may I take a point of personal privilege here for a moment, if my colleagues will let me?

Senator BREAUX. Absolutely.

Senator PRYOR. I have been running back and forth upstairs. There was another hearing on health care, and it was comparing our system to that of Germany, of Japan, and France. And we had a very fine GAO report, and I am sorry not to have been here for all of this fine hearing.

Let me, if I might, Mr. Chairman, just to take a moment to say a word on behalf of Dr. O'Donnell and the fine institution he represents, the Arkansas Children's Hospital.

Mr. Chairman and colleagues, yesterday in the Washington Post there was a story on page one about the unifying institution that brings everyone together—Democrats, Republicans, conservatives, liberals, you name it, farmers, ranchers, chicken growers—everyone supports one thing in this area. That is the Washington Redskins.

It is the one unifying institution that we have in our system in this town that brings us all together. The one unifying institution that we have in the State of Arkansas that brings all of our people together from all walks of life in every section of the State is the Arkansas Children's Hospital.

And it is one of the most unique and one of the most splendid institutions anywhere in America, Mr. Chairman. And to have Dr. O'Donnell, who runs that hospital, here today is really a treat, I know, for not only myself, but certainly the committee.

And I only apologize that the time is late and many of us have other meetings to go to, and I may not be able to stay during the entirety of his testimony.

But that will not demonstrate my lack of interest in what is said, nor my lack of commitment in what he is about in attempting to do to bring better health care in our State. Mr. Chairman, thank you. I thank my colleagues.

Senator BREAUX. Dr. O'Donnell, with that introduction, do you still want to testify?

Dr. O'DONNELL. Briefly I will.

STATEMENT OF RANDALL L. O'DONNELL, PH.D., CHIEF EXECUTIVE OFFICER, ARKANSAS CHILDREN'S HOSPITAL, LITTLE ROCK, AR, ON BEHALF OF THE NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS

Dr. O'DONNELL. First of all, I would like to say thank you, Senator Pryor. Your support of children in our State, and children in this Nation certainly goes without question, and I appreciate your kind remarks.

Mr. Chairman, I am Randall O'Donnell, chief executive officer of Arkansas Children's Hospital in Little Rock, and I am a trustee of the National Association of Children's Hospitals and Related Institutions. Thank you for the opportunity to testify.

My testimony is guided by the children's hospitals' extensive experience in caring for children who depend upon Medicaid for access to health care.

On average in 1990, an acute care children's hospital devoted nearly 40 percent of its care to children with Medicaid assistance. However, Medicaid reimbursed the hospital an average of only 72 cents for every dollar of cost it incurred to care for a patient. I am not speaking about a percent of billed charges, I am speaking about 72 percent of the cost of care.

In 1990, Arkansas Children's Hospital devoted 50 percent of its care to children assisted by Medicaid. We received less than 85 cents for every dollar of cost incurred to care for these children. Clearly, that discrepancy in reimbursement for service is not sustainable in the long run.

In addition to these inpatients, we are caring for a greater and constantly increasing number of children through our outpatient clinics. However, Medicaid reimbursement for outpatient care provides an even lower percentage of cost recovery.

The Medicaid patients of children's hospitals are at the center of the debate concerning HCFA's plans to restrict the ability of States to finance Medicaid.

This debate may be over technical and legal issues, but the impact of its conclusion will be felt first in the lives of the children and pregnant women who make up two-thirds of all Medicaid beneficiaries in this country. It also will be felt by the hospitals such as ours on whose care these children's lives depend because virtually all children's hospitals serve a disproportionate share of Medicaid patients.

Our hospitals are especially vulnerable to changes in Medicaid payment policy, and over 80 percent of NACHRI's member hospitals are located in States whose Medicaid programs are sustained, in part, by the use of Medicaid donations, taxes, or intergovernmental transfers.

For example, last summer, the State of Arkansas implemented a tax on the State's share of Medicaid revenues received by all health care providers.

With these tax revenues and the Federal matching funds they generate, the State of Arkansas is able, at a time of enormous economic difficulty, to fulfill your Medicaid expansions for children.

With these funds, we also are able to have a medically needy program, which helps the working poor who have catastrophic medical bills.

Arkansas' tax was developed with the broad support of the provider community and child advocates, Republican and Democratic members of our legislature, and our Governor. The State also worked in close consultation with HCFA regional staff to ensure that our tax would comply with the law, since HCFA was drafting its regulation. HCFA took more than a year to write its regulation which completely changed the rules of the game by reinterpreting 1990 Federal law.

Then the agency withdrew its regulation before all public comments had been submitted and issued a revised version only two-and-a-half weeks ago. This revised rule still is open to differing interpretations, despite the fact that it will take effect automatically on January 1.

The rules implementation will force many States to abandon their current Medicaid financing, or restructure it completely. The rule will leave other States, such as our own, without written determination of what policy changes, if any, the State will have to make.

In recent weeks, the staff of NGA and the administration have worked hard to reach a compromise, sorting through many technical issues. However, the scope of their compromise effort goes well beyond the regulation to include major changes in disproportionate share payment policy.

This involves policy matters that go to the very heart of the ability of children's hospitals to care for growing numbers of indigent patients. The issues involved and the tentative agreement are very complicated. They were developed without the participation of the affected community, either provider or consumer. They were reached under tremendous pressures of time and budget.

It is virtually impossible to assess accurately the impact of such a compromise agreement, especially when we have only a few days to do so, and no statutory language to review.

Mr. Chairman, the children's hospitals are enormously grateful for the leadership of this committee in improving Medicaid assistance for children.

We also support strongly the legislation of Senator Mitch McConnell to impose a year's moratorium on the issuance of the regulation. We understand that there are significant technical issues at play involving the requirements of the Budget Enforcement Act, which make enactment of moratorium legislation a difficult task.

It does not matter how the rules implementation is delayed, but it is essential that Congress, before it recesses, take action, both to prevent the HCFA rule from taking effect on January 1, and to ensure that Congress will have the opportunity to pursue the normal legislative process needed to develop a responsible compromise on this sensitive issue.

It is in no one's interest to see action on this issue delayed again and again without promise of conclusion, but certainly it is not in the interest of the 12 million children nationwide, and the 163,000 children in Arkansas who now depend on Medicaid to have Congress permit HCFA to implement its rule, or to have Congress enact in haste major policy changes so fundamental to children's needs, and the sustainability of children's hospitals' service to them.

Thank you for the opportunity to appear before you today. I would be pleased to answer any questions that members of the committee may have.

Senator BREAUX. Well, thank you very much.

[The prepared statement of Dr. O'Donnell appears in the appendix.]

Senator BREAUX. Next, Ms. Rosenbaum.

STATEMENT OF SARA ROSENBAUM, DIRECTOR, HEALTH DIVISION, CHILDREN'S DEFENSE FUND, WASHINGTON, DC

Ms. ROSENBAUM. Thank you, Mr. Chairman. Thank you for giving us the opportunity to testify today. I have been representing Medicaid beneficiaries now for about 17 years, and I have to say that in that time, I have never seen anything as astonishing as these rules.

And it is also hard to remember a time of legislative debate over an issue that was so profound to the future of this program as the current debate, and it is equally astonishing to me that even a remote attempt is being made to compress the debate into a matter of a few days, or a couple of weeks.

We urge in the strongest terms that a short moratorium be granted, and that whatever compromise is tentatively developed by the Governors and by HCFA come back to both the House and Senate for full legislative hearings, and full opportunity for normal input on such a fundamental change in the program.

We, probably more than anybody else, want to see a permanent solution to the issue of how States can generate the non-Federal share of the Medicaid program.

As long as Medicaid is not federally financed, as long as States are under tremendous pressure to meet the very, very high health care costs of people who are Medicaid beneficiaries, the issue of how they raise their funds will be, first and foremost, along with the standards that apply to the program.

But right now, this program is so big, and any actions that are taken to change the way it is administered are of such enormous portent that tremendous care has to be put into the changes that are made.

We have right now 12 million children in this country on Medicaid, and growing, because childhood poverty is so great, and because the number of children with private insurance is dropping.

There are over 1 million pregnancies a year covered through the Medicaid program. In many States, it is approaching half of all births. And, at a minimum, it is coming in now at about a third of all births—not all poor births, all births. It is the major financial program for all maternal and child health services. There is simply nothing that rivals it.

The rules themselves are simply untenable. On inter-governmental transfers, they change over a quarter of a century of normal governmental operations with respect to the Medicaid program, and the tax provisions obviously fail to carry out the agreement that was reached last year.

We are certainly encouraged by the negotiations that began several weeks ago, but the Governors have taken on what we think

is simply an impossible task, which is attempting to negotiate a reasonable solution in such a short period of time.

Most appalling to us in the negotiation at this point is any upper limit on the amount of lawful taxes that a State can use to run its Medicaid program.

The negotiations, as we understand it, address taxes in two ways. First, they specify what a lawful tax is. That has never been done before under the program, but certainly it is something that may be warranted given the very isolated examples of questionable tax policy that States have pursued.

But then to turn around and tell a State once a lawful tax has been put into place, that it can generate only a certain proportion of its non-Federal share from that tax is simply astonishing to us.

Why should the Federal Government tell a State how much of a lawful tax it can use to run its program? Why should it tell counties how much of a lawful tax they can use to run their program?

We consider the ceiling simply a back door attempt to impose the same cap on the Medicaid program that was objected by Congress in 1981.

And we do not think in a matter of days such an astounding agreement should be put into place. The disproportionate share upper payment limit is a similarly serious tax.

It will end up penalizing the very few hospitals and institutions still available to poor children and pregnant women. These hospitals account for an enormously disproportionate share of all the births and care for children that are provided.

Unfortunately, not all States and communities have very fine children's hospitals. On the issue of taxes, I think it is important to find out that this administration routinely sends Congress a litany of user taxes and special fees to run the various programs that the very same users benefit from.

And the best example I could think of sitting in the audience was the HCFA proposed survey and certification tax, which comes up here every year in which nursing homes that are to benefit from the Medicare and Medicaid programs are asked to pay for the cost of the survey and certification that will make them eligible for billions of dollars in payments.

We see absolutely nothing wrong with a tax that is declared by HCFA to be lawful. What we do think is wrong is to then turn around and tell States they cannot use that revenue.

Senator BREAUX. Thank you, Ms. Rosenbaum.

[The prepared statement of Ms. Rosenbaum appears in the appendix.]

Senator BREAUX. Ms. Shaw.

STATEMENT OF LUCY YATES SHAW, R.N., M.B.A., PRESIDENT AND CHIEF EXECUTIVE OFFICER, THE REGIONAL MEDICAL CENTER AT MEMPHIS, MEMPHIS, TN, ON BEHALF OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS, ACCOMPANIED BY LARRY GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Ms. SHAW. Yes. Good morning.

Mr. Breaux, before I start, you asked a question regarding these proposed changes on the State of Louisiana. And we have here with

us a table that we believe HCFA prepared for those negotiations that shows that Louisiana would lose over $150 million in disproportionate share payments if the 11 percent cap that they are discussing is imposed. So, you might be interested to have this, sir.

Now, I am pleased to be here with you this morning to have the opportunity to describe for you the potentially devastating impact on the Med, the regional medical center at Memphis, and other similar hospitals of HCFA's October 31 Medicaid financing regulations.

I am accompanied this morning by Mr. Larry Gage, to my right, who is President of NAPH, the National Association of Public Hospitals. Mr. Gage does not have a separately prepared statement, but he is available to answer any questions.

In summary, Mr. Chairman, the new HCFA rules will eliminate Federal matching payments for provider donations, greatly restrict Federal matching for services funded, in part, through provider-specific taxes, and to possibly even reduce or eliminate the ability of local governmental entities to participate in funding the Medicaid program.

In Tennessee and many other States, because of the increased demand for service by indigent patients and the weakness of the economy, these sources of funding have become an essential part of the Medicaid program.

I have submitted my prepared statement for the record, and will summarize its key points.

The Med operates a 460-bed major teaching hospital, with 22,000 admissions and over 200,000 out-patient and emergency room visits per year. Fortunately, 18 percent of our patients are private, 13 percent have Medicare, and 30 percent are Medicaid-eligible.

Unfortunately, over 40 percent of the patients we serve are uninsured. We deliver 8,000 babies a year, which is half of all the babies born in Shelby County. Close to a quarter of those babies are born to young females between the ages of 12 to 20, in an county with an infant mortality rate of 14.1 percent, and a State with a 10.7 percent infant mortality rate.

Most of these moms and babies—the ones who live—are covered under our State's aggressive presumptive Medicaid program, AFDC, or other federally-mandated enhancements.

We provide safety net services at the Med which cannot be found elsewhere within a 150 mile radius. These include an 80-bed neonatal ICU unit, which is the largest in the Nation; a high-risk OB service; a burn center, the only Level I Trauma Center in the region, and the only comprehensive outpatient AIDS clinic.

The new HCFA rules that we are here to talk about today will gravely jeopardize the lives and well-being of these moms, babies, and others.

Tennessee's provider tax program has allowed us to attempt to fill the ever-widening gap between available resources and the continued burdens of recession, lost jobs and incomes, inflation, and a sicker, dispirited mass of humanity.

The option for matching funds allow for Tennessee Hospital Industry to come together this past year to raise dollars to preempt an economic disaster in Tennessee which would have drastically cut services, benefits, and eligibility by nearly 50 percent.

Clearly, Medicaid has, for a wide variety of reasons, cost us more than is seemly, but there was no other resource. And we used the law as it was intended to be used.

Frankly, we want a long-range equitable solution to the financing of low-income care just as much as you do, just as much as Administrator Wilensky.

If local funding options are no longer available in Tennessee, it will mean disaster for our Medicaid recipients and our safety net hospitals. Tennessee stands to lose $550 million in Federal and non-Federal Medicaid funding.

At the Med, this will translate into $21 million in the first 6 months of 1992. This can easily translate further in 38,700 patient days, a quarter of our total payroll and benefits, 10,800 days in our burn center, and 32,000 days in our neonatal intensive care unit, and 132,000 outpatient visits.

This is only at The Met, and does not account for the other rural and urban disproportionate share hospitals across the State. This, in a State which in 1986 has generated dramatic improvements in our ability to take care of all, regardless of their ability to pay.

The annual 14-day limit on inpatient hospital utilization was increased to 20 days in 1987, then made unlimited in 1989. Eligibility expansion for pregnant women, infants, and children were made exceeding Congress' mandates. Now pregnant women and infants are covered up to 185 percent of the Federal poverty level.

This is significant when we talk about a program that we do not begin to ask, where did the money go? The money went for real lives, real patient care. In the State of Tennessee, we reduced from 1987 to 1989 the infant mortality rate from 11.7 to 10.8.

I would further add, NAPH strongly urges you to take immediate action to prevent HCFA from implementing these new rules by adopting an extension of the current moratorium, as set forth by H.R. 3595, and S. 1886.

Respectfully acknowledging the comments by the Senator from Iowa, provider tax and voluntary donation programs are not scams. In most States, the use of local funding sources has resulted in the often federally-mandated expansion and continuation of Medicaid eligibility and services.

More important, it has allowed an attempt, albeit inadequate, to improve access and institute quality efficient services for other uninsured indigent patients; those faceless voices, people who may not vote, who do not watch C-SPAN, but still depend on us and on you.

I would like also to reference something to the NGA proposals. I think, Senator Durenberger, you have been pretty supportive in terms of our own impression regarding that.

The discussions, compromise, or whatever it is, NAPH feels that unacceptable is any agreement which would be one which imposes arbitrary limits on States' use of provider taxes; one which inappropriately caps disproportionate share payments; and one which does not adequately address the availability of Federal matching payments for inter-governmental transfers.

We, too, feel that we are setting a bad precedent if all of those people affected are not at the table. We cannot set a precedent that

allows behind-the-door negotiations that do not have providers, recipients, or State Medicaid directors involved.

Now, finally, significantly, I must point out that the proposed regulations are clearly illegal. They violate the OBRA–90 agreement on provider taxes. They also violate Section 1900(a)(2) of the Medicaid Statute.

In fact, it was a Senate Amendment to the 1965 statute which was adopted by conferees in 1965 in lieu of a House requirement for 100 percent of State funding.

In light of our belief that these new rules are illegal, a group of NAPH member hospitals, led by Atlanta's Grady Memorial, asked the Federal courts last Thursday to declare these regulations illegal.

While we are hopeful that the courts will overturn these illegal regulations, we would prefer that Congress would give itself ample time to deliberately and carefully consider these highly complex issues.

We are not, in the words of Administrator Wilensky, daring you to take away the match. Actually, we are daring you to take the time to offer us the leadership position in structuring an equitable and meaningful global alternative for financing indigent care in this country. Thank you very much.

[The prepared statement of Ms. Shaw appears in the appendix.]

Senator BREAUX. Thank you, Ms. Shaw. And thank all the members of the panel for your presentations. From my perspective, I mean, there is no question about the importance of Medicaid.

And I think almost everyone on the panel talked about how your individual facilities, and your States, and institutions you represent are affected, and the people that are served by Medicaid.

My perspective, from what I am seeing, is that we are talking about a more narrow concern right now, and that is we have a program that is a federally matching program, and that there is a perception by some in government that some States are using a taxing situation, or voluntary contributions to merely end up with what, in effect, is 100 percent contribution.

We are not arguing about the merits of Medicaid and the people that it serves. I mean, there is no question that we need more, we need expanded, we need better facilities; that is all a given.

But from this Senator's perspective, we have a program that is a Federal matching share program, and it seems, as some have indicated in the examples given, that there are some States who are, in fact, raising the matching share from a particular provider through their tax situations, and giving it right back to them in the same ratio that they provided the tax; in effect, creating a 100 percent Federal program.

Now, that may be a good idea, but right now, that is not the law. Anybody comment on that observation?

Mr. DIXON. Well, Senator, the HCFA regulations that are before us at this point are minimally overreaching, and most concerningly, so ambiguous that I believe you have heard much about the potential of State or provider abuse.

I believe the current HCFA regulations invite OMB abuse in times of severe budget pressure at the Federal level. Those regula-

tions, if allowed to become law, in my opinion, could destroy the Medicaid program in many of our States.

Senator BREAUX. California has a voluntary contribution.

Mr. DIXON. We have a voluntary contribution program.

Senator BREAUX. What kind of an arrangement do you have with those who make the contribution to get that voluntary contribution covered by their reimbursement?

Mr. DIXON. We do not have a so-called hold harmless agreement, and, indeed, are not contemplating continuing our voluntary contribution program beyond January 1, and have adopted an intergovernmental transfer program that we are currently looking forward to HCFA approval of, Senator.

Senator BREAUX. What does that allow?

Mr. DIXON. I beg your pardon?

Senator BREAUX. What does that allow?

Mr. DIXON. That provides for county governments to provide county general fund money to the State as an inter-governmental transfer, which we believe is entirely consistent with current Federal law, and, indeed, believe it is consistent even with the new HCFA regulations.

But herein comes our problem: the new HCFA regulations are so ambiguous, I suggest to you that five well-meaning people could read those regulations and come up with six different interpretations.

Senator BREAUX. But I take it the thrust of Dr. Wilensky's proposal is not to affect inter-governmental transfers. I do not see anything in the proposals that affect inter-governmental transfers in order to make the match.

Mr. DIXON. Senator, we hope that that is correct. Our concern is that the regulations are so ambiguous, we cannot be confident of that.

Senator BREAUX. So, the concern that I think some have—and the fact that I think all of us with some responsibility for getting a handle on the Federal budget which is outrageously out of balance—is the question that if we have a Federal program that pays for a program that requires participation by the State, but allow the States to, in effect, enact a tax which the local provider gets back, we end up having the States basically able to set the standards and the Federal Government pay for the cost without any control, or any real contribution from the local communities.

Dr. O'DONNELL. Senator, may I just speak to that briefly? In the case of our own local situation in Arkansas, the health care providers—which includes not just hospitals, but all health care providers; physicians, pharmacies, and the like—are at risk for the tax dollars that they put up.

If the State of Arkansas comes up with a budget shortfall, as they are facing right now, the amount of payment to providers is at risk. And so, there is no guarantee that those funds will, in fact, be returned.

Senator BREAUX. Suppose the State of Arkansas does not have a short fall. What are the providers guaranteed?

Dr. O'DONNELL. The providers are not guaranteed anything. What happened was that the providers had been seeking for a number of years a reasonable cost reimbursement rate from the

State Medicaid agency. And after the passage of the tax through our State Legislature, the Medicaid program did, indeed, improve the payment rates to the providers.

Senator BREAUX. Have any other providers in Arkansas not received back at least as much they have contributed in the provider tax?

Dr. O'DONNELL. To this date, I do not believe that would be the case, no.

Senator BREAUX. Ms. Rosenbaum.

Ms. ROSENBAUM. I think there are two issues on the table. One is what is the structure of the tax, and the other is how much of that tax can be used. I think it is absolutely fair for the Federal Government to expect a broad fare tax. I think it is good policy for the government to promote a broad fair tax, and I think it has the right, as the Federal side of the Medicaid program, to define what a broad fair tax is.

And I think it is also fair for the government to make sure that the tax gets paid. I do not think that phantom taxes are an appropriate arrangement.

But there are two aspects of both the rules and the agreement that are very problematic, both for taxing and for inter-governmental transfers.

It is true that the agreement corrects the problem in the September 12th rule insofar as the September 12th rule declared unlawful inter-governmental transfers.

But where the agreement breaks down is that the localities making the transfer—the County of Los Angeles, a hospital district in Texas—cannot generate the revenues that it needs to make the transfer, essentially, from a provider-specific tax, if it happens to be a State that uses a provider-specific tax because of the 22 percent cap.

Now, that is not to suggest that in most States taxes amounting to more than 22 percent of non-Federal expenditures are in place, but to the extent that a set of State and local governments sit down and fairly apportion broad class-wide taxes to be levied at different levels of government and all to go back up to the State to run the program, I do not see why that is not an appropriate State financial decision. And to that extent, the transfer rules are not a correction. We still have this problem.

Senator BREAUX. Do you interpret the situation you just outlined as being prohibited by the proposed regulations?

Ms. ROSENBAUM. The proposed regulation unquestionably prohibits the use of either voluntary or mandatory inter-governmental transfers. Dr. Wilensky has, I think, agreed that the interim final rule was drafted to go far beyond just tax scams and donation scams.

And, in fact, if you look at the preamble to the September 12th rule, it is pretty clear that it was not an inadvertent mistake. There were questions and there were comments filed by us, as well as other people, about whether or not inter-governmental transfers were to be reached when the rules first appeared in 1990, and the answer was, absolutely, we intend to reach them.

Now, they have backed off from that position. But the further question is, what is the source of the revenue for the transfer?

HCFA can still stop a transfer to the extent that the transfer uses revenues that are subject to a cap, and that is the problem.

It is specious in some ways to suggest that the revenues can all come from county property taxes at this point. There are many States and localities that simply do not have a county property tax base, or have limits.

The only source of funding elastic enough to run the Medicaid program now is all the health funding that runs through the system that States cannot get at because of ERISA. They have to take the providers at the point of service, otherwise they cannot get at the revenues.

Senator BREAUX. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, thank you for sticking around until 6 after 1:00. I stayed around to thank the members of the panel for not only being here today, but I guess we have worked with all of you over time to try to expand Medicaid so it will do a better job. It is not your fault that we did not authorize the taxes to pay for it, and that sort of thing. So, I appreciate the fact that you are all here speaking to the interests that are elected or appointed in one way or another to represent.

Lest there be any mistake about my view on the subject, I have always believed in Federalizing access for low-income persons, and I think this system, as we have described it today in three-and-a-half hours is ridiculous, and you know that. I do not have to lecture the remaining people in the room on that subject.

I really do believe the poor in America ought to buy their way into the health care system the same way the rest of us do, with a membership in a health plan.

To the extent that they cannot pay for that, and, by definition they cannot, the social insurance system in this system ought to help them do it. Some combination of tax subsidies and social insurance. It ought to be left to State and local government to wrestle with the financing part of the problem.

Having said that, I also believe that the public health part of this problem, and the immunizations, the pre-natal care, and all of that sort of thing, ought not be left to the health plan or the insurance system.

I mean, if we can find a way to put public education in every neighborhood and every community in America, we ought to be able to find a way to do that in Los Angeles, and Memphis, and Minneapolis, and St. Paul.

The Labor and Human Resources Committee is continuing the process of developing more categorical participation in delivering immunization and health promotion and disease prevention programs, telling the State and local government exactly what we want, how you ought to do it, and not sending any money along to do it.

If I had my druthers, I would take over the responsibility for financing access for the poor to hospitals and doctors for their medical care, and I would hope that the State and local government would pick up the responsibility for the public health of people.

We would not back out of the system, but we would draw, as Laughton Childs has told us in one of these committees a few months ago, if we drew a bottom line under all the money we are

currently spending and sent checks to people at the local government level who are responsible for trying to deliver these services without telling them exactly how to do it, but setting some national standards for health, working on the lifestyle issues, some of these sort of things, that that might be a more appropriate role.

Now, having said all that, let me also say that I still have a hold on the House moratorium bill. I am prepared to stay here at least until November 30th with that hold.

But I have also been persuaded by listening to all of the testimony today—and particularly I read all your statements before you got a chance to deliver your abbreviated versions—I believe this is a more complicated problem than the HCFA regulation or the negotiations that have taken place since then would lead anybody to believe.

I do believe that in the end, much of this needs a legislative solution. We are talking about big-time issues here, and we are talking about real people.

What I hope is if there are some of these issues, I am sensitive to Iowa and Rhode Island, and some of these places, who have not acted yet, but are under the same pressure as everybody else. Are we going to go into the $4 for one scheme? The pressure is there to do something next year. I am really very sensitive to that fact.

I would hope in the negotiating process, whatever that may be, first, that more people get involved than just the Governors, HCFA and OMB.

Secondly, we try to figure out if there are not some things we can all agree on fairly quickly. If it needs a legislative solution, perhaps we can find a way by next Tuesday to get the legislative solution. Then we will define what is left and set ourselves some parameters for dealing with those solutions.

I leave you with only one other comment, particularly for the last two witnesses. I remain deeply troubled by provider taxes. By the notion that just because it is easy to add the cost of the poor to the care for the rich, now we are just going to add another dimension to that with taxes. It really flies in the face of dealing with the way in which health care is delivered most efficiently, if I dare use that word.

And I know, now it's the AFL–CIO, sooner or later it will be somebody else saying, no to sick taxes, that sort of thing. I hope that does not continue to be an absolute barrier to any of your associations in trying to help us figure out an answer to this problem.

With that, Mr. Chairman, I conclude my comments, and express my appreciations to all of these people for the very difficult work they undertake.

Senator BREAUX. Well, there may be additional questions that we would like to submit to the panel. I think they have made a very real contribution, and we thank you for it. With that, this panel will be excused, and the committee will stand in recess.

[Whereupon, the hearing was adjourned at 1:12 p.m.]

APPENDIX

Additional Material Submitted

Prepared Statement of Senator John Breaux

Mr. Chairman, thank you for holding this hearing and for the chance to examine the affect of HCFA's most recent set of proposals on state Medicaid programs. As the costs of Medicaid continue to soar and as the program takes up a larger and larger proportion of state budgets, the question of where the states' and the federal government's share of Medicaid funds will come from becomes more pressing.

Louisiana has a temporary voluntary donations program in place, which will, of course, end when the OBRA '90 moratorium expires. The state does not have a provider tax program. My state's earlier concerns about intergovernmental transfers seem to have been taken care of with HCFA's clarification of the interim final rule as issued on October 29, 1991.

Ultimately, Congress and the Administration are going to have to settle this issue of what kind of taxes are acceptable at the state level for paying for the state share of Medicaid. As Dr. Wilensky will no doubt tell us today, if we don't decide on a policy the problem will only get worse and the costs associated with implementing a rational policy will grow.

Congress has twice imposed a moratorium on HCFA rulemakings and we are here today discussing a third. I hope that today's hearing will shed some light on what kind of policy ultimately needs to be established. I do not have the solution. I hope, however, that the system can retain some flexibility for states, which are faced with severe fiscal pressures and mandates from Congress to increase coverage under the Medicaid program.

I am very concerned about proposals that would affect the states' ability to define and set payments for disproportionate share hospitals. We have a unique system of state-run Charity hospitals in my state of Louisiana, which depend heavily on the disproportionate share adjustment. HCFA has drafted legislation and regulations that would limit the state's ability to pay for indigent care in these facilities.

What's more, OMB, HCFA and the National Governors' Association have brought disproportionate share into their negotiations on provider taxes. HCFA's rationale for doing so seems to be that a number of states use disproportionate share as a way of rewarding hospitals for their participation in provider tax and voluntary donation programs. This is not what is done in Louisiana. The nine Charity Hospitals in the state receive $278 million of the $350 million paid out by the state under disproportionate share. A huge amount of indigent care is accounted for in this fashion.

About 1 million people in LA have no health insurance and at some point in their lives might have to fall back on the free care that they can receive in the state Charity hospitals. I would not want to see this endangered by a regulatory move that is contradictory to the intent of the disproportionate share program.

Now that I have made my concerns on this point known, Mr. Chairman, I yield. Thank you for the opportunity to speak.

Prepared Statement by Senator John H. Chafee

I would like to commend the chairman for convening today's hearing on voluntary contributions and provider specific taxes. This is a very complicated and sensitive issue which we as Finance Committee members have dealt with for a number of years.

I am very sympathetic to the plight of states struggling to finance their state Medicaid programs during these difficult budgetary times. New England states have been particularly hard hit. The federal government should give states flexibility in raising revenues for state programs. I am concerned, however, about certain programs that states have implemented in recent years that clearly are inappropriate and have resulted in increasing the federal share of Medicaid funding to states. Of particular concern are those states that accept money from providers assuring the providers that they will be made whole through reimbursement or other means.

We must keep in mind however, that this is more than just a matter of the States trying to cheat the federal government out of billions of dollars in federal matching funds under the Medicaid program. This year states are expected to spend forty billion on Medicaid, and within the next five years, that figure will double. It is imperative that we reach an agreement on this issue without a serious disruption in Medicaid services. And make no mistake, the regulations, as issued will do just that. Families will lose services.

Last July, the Subcommittee on Health Care for Families and the Uninsured held a hearing on this issue, and I urged the National Governor's Association and the Administration to sit down and negotiate guidelines that would be mutually acceptable I was glad to hear that they have been working together.

Last year in budget conference we worked out an agreement with the Administration. Dr. Wilensky was there, as was my colleague from Florida, Senator Graham, and members of this, Committee, Senators Pryor and Rockefeller. We agreed that voluntary contributions would no longer be allowable after December 31 of this year. In addition, we made it clear, if anything is clear at 2 a.m., that we would allow the use—of provider taxes with some limitations.

However, even knowing that voluntary contributions were prohibited after December 31, some states enacted voluntary contribution programs this year. Now either they were trying to jump on the gravy train and get all the federal dollars they could before it expired, in which case, I wonder if Rhode Island was asleep, or alternatively, States believe that Congress did not intend to let the regulations be implemented. I can understand how they would think that. We've been issuing moratoriums on these regulations since 1988.

I have serious concerns about implementing a moratorium on the Administration's regulations through September of next year. We have postponed resolution of this issue for too many years. It must be resolved now. I fear that another delay will send inappropriate signals to the states. Much progress has been made in this area over the past few weeks in negotiations between the States and the Administration. I am hopeful that this issue can be resolved in the near future.

I would strongly urge both sides to continue their discussions and reach a mutually acceptable solution to this very serious problem. I welcome the witnesses to today's hearing and look forward to their testimony.

Prepared Statement of Robert "Chuck" Chambers

Mr. Chairman and members of the Senate Finance Committee: My name is Robert "Chuck" Chambers and I am Speaker of the West Virginia House of Delegates. I have had the pleasure of serving in the West Virginia House of Delegates since 1978 and was first elected Speaker in 1986.

I am a member of the Executive Committee of the National Conference of State Legislatures, and appear today to comment on the Administration's efforts to curtail state's use of provider-specific taxes and voluntary donation programs. As you know, NCSL represents the legislators of the nation's 50 states, its commonwealths, and territories. My testimony is based on policies adopted by NCSL's State-Federal Assembly, the policymaking body that guides our advocacy activities with Congress, the courts, and federal administrative agencies. NCSL policies reflect our dedication to preserving a strong federal system of government, maintaining effective intergovernmental programs, protecting our nation's most vulnerable populations, and developing creative and constructive domestic initiatives.

I speak for my colleagues across this country when I say it is hard to believe that we are less than 45 days from the January 1, 1992 effective date of the U.S. Department of Health and Human Services regulations that will wreck havoc on Medicaid programs across the country and we have no commitment from the U.S. Congress to address this issue before it adjourns next week.

This is a critical issue. In many ways this issue is as important as additional financial assistance to the unemployed. After all, when the unemployed lose their health care benefits, many of them will ultimately depend on the Medicaid program for access to care.

State legislators are both frustrated and troubled about the lack of progress that has been made on this issue. We are frustrated because we cannot plan. We must assume the worst in developing our budgets for the upcoming fiscal year. We must assume that these funds will not be available and that we will have to initiate reductions in services or tax increases to fill the gaps. We find it particularly troubling that bureaucrats within the Health Care Financing Administration (HCFA) and the Office of Management and Budget (OMB), non-elected staff people, can redefine Congressional intent through the regulatory process, effectively putting us in this situation and getting away with it.

We need a legislative fix to this problem. We need your active involvement in this process. However, I believe it is impossible to craft a reasonable compromise prior to your adjournment before Thanksgiving. Given the time constraints and the complexity of the issues, we believe the most prudent course is a moratorium. The moratorium should be tied to a commitment to bring the principals of the affected entities together to develop a fair and equitable compromise that everyone can live with.

The current negotiations between the National Governors' Association and the Administration are laudable, but too limited in scope. Executive branch representatives can meet and propose recommendations, but you and I know that it is the legislative branch that disposes of these recommendations. In addition to the Administration representatives and governors, future negotiations should include state and federal legislators, county officials, hospital and other provider representatives and advocates for the poor. All of these perspectives are important and will help create a compromise that takes every group's concerns into account.

I know that some of you on this committee are opposed to a lengthy moratorium. We could support a shorter moratorium if it were tied directly to a commitment to convene a summit of the affected groups to develop a compromise legislative package for consideration by Congress early next year. The critical thing for all the states is to get past this January 1, 1992 drop dead date and to work out something more reasonable that protects Medicaid beneficiaries from abrupt program reductions and the elimination of some services.

If a short term moratorium were to be adopted, with the understanding that a compromise delineating specific guidelines for provider-tax programs would be developed, it is imperative that reasonable transition provisions and effective dates that are sensitive to state legislative fiscal years and session dates be adopted as part of the overall compromise. One of the major shortcomings of the NGA/Administration proposal is its lack of consideration for biennial states. I would also note that West Virginia is also not covered under the grandfather clause because we passed legislation after September 30, 1991.

We firmly believe that capping the amount of state funds that can be derived from provider-specific taxes and capping Disproportion Share Hospital payments is not required to address either Administration or Congressional concerns regarding state's use of provider-specific taxes. NCSL has a longstanding policy opposing the capping of entitlement programs. We are very interested in exploring other options with all interested parties.

We also believe that HCFA should steer clear of telling states how to tax and who to tax. While we agree that states should not be permitted to guarantee specific payments to specific institutions participating in the provider tax, we oppose additional "linkage" provisions that result in the micromanagement of state government by the U.S. Department of Health and Human Services.

Finally, we believe that future negotiations should be limited to the issues addressed in the Omnibus Budget Reconciliation Act of 1990. This would preclude discussions of intergovernmental transfers and non-institutional providers. We also believe that changes to the Medicaid disproportionate share program be addressed separately.

On behalf of the membership of the National Conference of State Legislatures, I urge you to take immediate action on S. 1886, the Senate companion bill to H.R. 3595, the Medicaid Moratorium Amendments of 1991. We look forward to working closely with you in the coming months to resolve this issue.

I thank you for your kind consideration of our interest and concerns.

Prepared Statement of Richard Dixon

Good morning Mr. Chairman and members of the Senate Finance Committee. I am Richard Dixon, chief administrative officer for Los Angeles County. On behalf

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of the National Association of Counties (NACO),[1] I want to thank you for this opportunity to testify.

NACo supports S. 1886. A moratorium on the Health Care Financing Administration's (HCFA) interim final regulations is the only reasonable approach to providing adequate time to forge a satisfactory solution to this complex and difficult problem. I urge your assistance in passing whatever legislation is necessary to achieve this end.

The representatives of the National Governors' Association (NGA) have made a well-intentioned, good faith effort to negotiate a compromise package with the Office of Management and Budget and HCFA. But, after review, the resulting proposal falls far short of meeting the critical needs of California and numerous other States, counties and their disproportionate share hospitals. It has become obvious in the last few days that the complexity of the issue precludes a timely compromise. No one should be lulled into a false sense that an acceptable compromise can be achieved soon. I will provide you with a summary of Los Angeles' concerns over the latest proposal.

Because this session of Congress nears an end, passage of S. 1886, and its House counterpart, H.R. 3595, is critical to allow Congress, the administration, States, and counties adequate time to carefully assess the impact of the regulations and consider preferable alternatives. Additionally, any alternative must permanently prohibit HCFA from issuing regulations affecting intergovernmental transfers. Funding must be preserved for safety net hospitals, such as those run by Los Angeles County, and many others to address the growing problem of inadequate access to care for the medically indigent.

The bill must be passed because, despite the October 31, 1991 "clarifying" regulations, the interim rules continue to be ambiguous. Moreover, they appear to violate existing law and OBRA 1990. This violation of congressional intent is most evident with respect to provider taxes and intergovernmental transfers. If implemented on January 1, 1992, the regulations will create chaos for State and county budgets and their programs serving the indigent.

Why are the nation's counties concerned about this issue?

County participation in Medicaid has been a long-standing practice since the enactment of Medicaid. Attached to the testimony is a chart outlining our direct involvement in appropriating matches. Many counties also transfer or certify funds through their public hospitals, long term care facilities and health departments. Participation through county matching dollars and intergovernmental transfers has never been questioned. In fact, the statute specifically allows up to 60 percent of the non-federal match to be from local entities.

In addition to providing care and/or funding Medicaid, counties in over 30 States have the legal responsibility to serve the indigent. According to the most recent census data, during 1979–1989 county expenditures on health grew by 72.5 percent after inflation while counties raised their own revenues by nearly 50 percent. In terms of actual dollars spent, counties in 1987 contributed $18 billion of their own revenue to health and hospitals. During this same general period (1980–1986) the congressional research service reports that direct federal assistance to counties fell as a percentage of total county revenues by 73 percent.

Those figures show that counties are devoting ever-increasing resources of their own to health care and are raising revenues to meet those needs. alternative Medicaid funding mechanisms are not being used by counties or states to shirk their responsibilities to care for the poor.

Counties, like all levels of government, face exploding medical cost inflation, recession and increased service demands. This should be the time for fostering financing mechanisms—it is not the time to use regulations as a blunt tool for federal cost containment.

As the governmental entities most often responsible for indigent care, we know first hand that the disparity of medical care access between the "have's" and "have nots" in our society would increase further, and adverse medical care outcomes will become more prevalent. For example, last Friday's Los Angeles Times reported on a recent study indicating that black infant deaths in California exceed those of whites by 2½ times, up from a 2.1 ratio ten years ago.

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[1] The National Association of Counties is the only national organization representing county government in the United States. Through its membership, urban, suburban and rural counties join together to build effective, responsive county government. The goals of the organization are to: improve county government; serve as the national spokesman for county government; serve as a liaison between the nation's counties and other levels of government; achieve public understanding of the role of counties in the federal system.

Recently enacted California legislation (S.B. 855) provides for an inpatient medical disproportionate share payment adjustment program that would provide critically needed funding to maintain the medical safety net in the State. The State plan amendment, which awaits federal approval, is jeopardized by the HCFA regulations. It is important to note that California county participation is not new. Until 1978, counties participated in matching funds for Medicaid. I will provide you with a briefing paper on the S.B. 855 program.

Failure to obtain federal approval of the S.B. 855 program will have substantial adverse impact statewide. Perhaps nowhere will the impact be felt more severely than in Los Angeles County.

—Los Angeles county operates six public hospitals, five comprehensive outpatient health centers and 42 community health centers, and has the highest rate of uninsured persons in the nation. At least 2.7 million of the county's residents are uninsured, nearly half those in the entire state.

—Of the county's hospitals, three are major teaching institutions, and are designated trauma centers. LAC+USC medical center is often considered the largest medical center in the nation. MLK/DREW medical center, located in South Central Los Angeles, was born out of the 1960's watts riots and is the key health care facility for that entire area. Rancho Los Amigos medical center is one of the nation's premiere rehabilitation hospitals.

—based on recent federal data, the Medicaid activity of our hospitals is greater than the entire Medicaid program in 18 states.

—workload in Los Angeles county-operated hospitals has grown dramatically since FY 81–82, as follows:

admissions	39% (139,000 to 193,000)
ambulatory care visits	137% (950,000 to 2,250,000)
births	131% (26,000 to 60,000)

Much of this growth is the result of foreign immigration over which the state and county have no control.

—The cost per day in Los Angeles county-operated hospitals is already 13% below the statewide average and 33% below comparable institutions. Capital needs that largely remain unaddressed and accreditation/certification problems have resulted from severe budget constraints.

—The failure of revenue to keep pace with spiraling workload and cost increases, and California's precarious fiscal situation, have forced Los Angeles County to anticipate over $300 million this fiscal year from S. 855 to maintain existing health and mental health care programs.

Specific service cuts which would be needed this fiscal year if these revenues are not received have yet to be determined. However, by way of example, they would require service reductions roughly equal to the entire operations of LAC+USC medical center and Martin Luther King, Jr./DREW medical center. These reductions would include almost 600,000 inpatient days (a 55% systemwide cut) and almost 800,000 outpatient visits (a 35% systemwide cut) per year. About 12,000 jobs would be in jeopardy. Mental health services, already substantially insufficient, would also be adversely impacted.

Such program curtailments would come at a time when countywide emergency trauma and obstetrical service capabilities are already severely strained and uncompensated care burdens are at record levels. A collapse of the trauma and emergency care system would be likely. Ten hospitals have withdrawn from the county's trauma system since it was implemented in 1983. Non-county operated institutions would be forced to close or reduce their trauma and emergency services to avoid an influx of uncompensated care patients. Such a collapse would substantially reduce healthcare access to all Los Angeles County residents and all visitors to the region.

—Populations that have seen the most recent improvement in services and coverage—including poor pregnant women and children—will suffer the most, as with those uninsured indigent patients served by the most significantly "disproportionate" health care providers of care to the poor.

California accounts for 14% of all Medicaid recipients, but only 8.8% of all federal Medicaid expenditures. Even when S. 855 is approved by HCFA, California's share of Medicaid expenditures will grow to only about 10.5%, still 25% below national equity. Forty-five states' Medicaid programs currently pay a higher percentage of inpatient costs than California.

Many counties in many states are equally concerned. Michigan has already eliminated its general assistance and G.A. medical programs. Next year, without voluntary contributions, Michigan would be forced to eliminate optional Medicaid programs like oxygen, wheelchairs, transportation and replacement of joints. The State will also be forced to eliminate home health care and cut AFDC grant levels by an-

other 12 to 18 percent. county based medical care facilities in Michigan will also suffer.

In Minnesota, loss of the medical assistance surcharge will mean that counties, legally responsible for the indigent, will be forced to again raise property taxes or cut services.

In Florida, the three counties with the largest number of Medicaid patients (Dade, Duval, Hills Borough) are transferring funds through their publicly-supported hospitals. St. Louis City and county participate in a similar intergovernmental transfer program with the state of Missouri. The city and county fund the St. Louis regional medical center of which 92 percent of the patients are indigent or eligible for Medicare or Medicaid. Loss of the transfer program could mean that the fragile public and private hospital system of care could collapse.

In Pennsylvania, the State ran out of money for Medicaid payments to nursing homes in may. Counties operate about 30 percent of those facilities. Two-thirds of the counties have increased taxes in each of the last five years. The tough decision to increase taxes resulted in a 42 percent turn-over in county commissioners on November 5, 1991. The Pennsylvania program is just one component to saving nursing homes.

In Wisconsin, part of the county property tax funds county nursing home operations. Their provider tax program is integral to continued operation of those facilities.

Counties in New York contribute $2.6 billion to Medicaid. They pay for 20 percent of the non-federal share of long term care and half of the non-federal share for all other services. The ambiguity of the regulations leaves even these long-standing arrangements in question.

In Ohio, without the "care assurance" program, the Cuyahoga County (Cleveland) hospital will lose over $6 million. Services will have to be cut. The Cleveland area hospitals already absorbed $150 million in uncompensated care in 1990. Without the expansion of the care assurance program, 140,000 general assistance recipients will lose coverage after July 1, 1992.

County-funded public hospitals in Georgia contribute to their indigent care trust fund to help hospitals serving the poor and to expand a wide variety of prenatal and child health services. In Illinois, one of the largest public hospitals in the country, operated by cook county, will be assessed a tax to increase funds available to Medicaid providers. In South Carolina, counties formed a partnership with hospitals to create a medical indigent assistance fund to care for the poor. These are just a few examples.

While the ultimate solution to this issue may be a comprehensive national health care program, even the most ardent supporters recognize such a program could not be enacted and phased-in quickly. For the time being, adequate federal funding of Medicaid is the only solution available. Counties and the country cannot afford to allow the Medicaid program and urban safety net hospitals to crumble in the interim, with disastrous effects on hundreds of thousands of Americans.

S. 1886 and H.R. 3595 are the only reasonable and appropriate approaches now to this complex issue. A moratorium will provide adequate time to forge an acceptable solution. Such a solution must clearly outline appropriate provider tax programs and must be unequivocal on affirming the continued use of intergovernmental transfers.

This issue will remain NACO's top health priority until it is resolved. On behalf of NACO, thank you for this opportunity to testify.

County funding formulas for Medicaid by state

Arizona
Under Arizona's Health Care Cost Containment System (a statewide Medicaid demonstration project), counties pay 100 percent of the non-federal share of long-term care for the elderly and physically disabled, and fund a variable portion of acute care services.

Colorado
Counties pay 40 percent of the non-federal share of administrative costs related to eligibility.

Florida
Counties pay $55 per month for each nursing home resident, and 100 percent of the non-federal share for the 13th through 45th inpatient hospital days.

Iowa
Counties pay 100 percent of the non-federal share of ICF/MR; 100 percent of the non-federal share of MH/MR/DD waivers for home and community-based services for persons normally served by ICF/MR; and 50 percent of the non-federal share of certain mental health "enhancements" (i.e., Title XIX case management, partial hospitalization and day treatment for the chronically mentally ill, mentally retarded and developmentally disabled).

Minnesota
Counties pay 100 percent of the non-federal share of administrative costs related to client services except for the child health plan, where the share varies. Counties also loan funds to the state, without interest, for a portion of the state's benefit payments for the first six months of each fiscal year.

Montana
Counties pay 18 percent of the non-federal share of administrative costs related to eligibility.

New Hampshire
Counties pay 61.5 percent of the non-federal share of intermediate nursing care services, except for ICF/MR.

New York
Counties pay 20 percent of the non-federal share of long term care; and 50 percent of the non-federal share of all other services.

North Carolina
Counties pay 15 percent of the non-federal share of services, and 100 percent of the non-federal share of administrative expenses.

North Dakota
Counties pay 15 percent of non-federal share except for: ICF/MR, clinic services, and waivered home and community-based services for mentally retarded, aged and disabled recipients. In the 1989-90 biennium, the county share averaged 9.8 percent of the non-federal share of all services.

Ohio
Counties pay 10 percent of the non-federal share of administrative costs related to eligibility, subject to certain limitations.

Pennsylvania
Counties pay 10 percent of the non-federal share for county nursing homes plus $3 per invoice.

South Dakota
Counties pay $60 dollars per month for each ICF/MR resident; and $200 per month for each mental health resident in state inpatient facilities.

Utah
For mental health, counties must provide a match equal to 20 percent of the amount paid by the state, which is equivalent to 16.7 percent of the non-federal share.

Wisconsin
Counties pay the non-federal share for certain mental health programs (i.e., community support program services and targeted case management), but up to 90 percent of the county match may be offset by funding provided by the state through payments to counties under the state's "community aid for human services."

(Table compiled by Kathy Gramp, NACo budget analyst, from state associations of county officials and state Medicaid officials — September 1991.)

PREPARED STATEMENT OF SENATOR BOB GRAHAM

Mr. Chairman. Thank you for convening today's hearing on provider taxes and donations and for allowing me to testify.

All of us here have followed closely the provider tax and contribution issue. After Section 4701 of the Omnibus Budget Reconciliation Act of 1990 was enacted last year, the Administration issued regulations interpreting the law. Because the September 12, 1991 regulations were too vague, the Administration reissued "clarifying regulations" on October 29.

Many Governors and members of Congress expressed discontent with the Administration's interpretation of statute. For this reason, the states and the Administration began negotiations on a compromise approach.

To this point, negotiations between the states and the Administration have failed to achieve an acceptable compromise position. It is unclear whether the Administration's regulation, a negotiated compromise, or a Congressionally passed moratorium will go through.

Mr. Chairman, this issue has been the focus of much recent controversy and confusion. It is my feeling that the current regulation goes beyond statutory authority. For this reason, I will reiterate last year's events leading up to the enactment of S. 1878, legislation which introduced.

I first discussed the provider tax issue with Dr. Wilensky on February 1, 1990 when her nomination as HCFA Administrator was before the Senate. At that time, few states were aware of or concerned with the provider tax and donation issue, and I wanted to ascertain that the Administration thoroughly understood the substance of Florida's tax.

At the conclusion of our meeting, Dr. Wilensky vowed to find a way to continue "above board" provider tax programs with certain restrictions.

During our meeting, I was quite impressed with Dr. Wilensky's understanding of this and other issues. In all our discussions over the past year and a half, Dr. Wilensky has been thoroughly professional and open with me and other Florida delegation members on the provider tax matter.

Last fall, Dr. Wilensky and personally discussed Section 4701 of OBRA 1990. The September 12 and ensuing clarification regulation is not entirely consistent with our agreement. My recollection of this agreement is as follows.

At the conference table, the Senate position was to extend the existing moratorium prohibiting final regulations to disallow Medicaid spending based on provider taxes or contributions from December 31, 1990 until September 1, 1991. The House position was to allow States to receive Federal matching payments for Medicaid spending financed by taxes on providers.

After negotiations, the compromise language determined:

- that the Secretary has no authority to deny or limit payments to a State for expenditures, for medical assistance for items or services attributable to taxes (whether or not of general applicability) imposed with respect to the provision of such items or services and
- that there is the exception, specially requested by the Administration, which denies Federal Medicaid matching funds for payments to hospitals and other institutional providers for the costs attributable to taxes imposed by the State solely with respect to hospitals or facilities.

When Dr. Wilensky presented these provisions to me during negotiations, contacted the Florida Medicaid Director, who then spoke directly with her. The extent of all our conversations was entirely on the subject of attributable costs.

Mr. Chairman, the regulation goes beyond statutory authority and, specifically, a carefully worked out compromise. Our agreement was that States can use revenues from provider taxes to finance Medicaid spending, except that any reimbursements to institutional providers that are paid on a cost basis may not include as an element of cost the expense attributable to a provider tax.

The Administration's rule, however, denies Federal matching funds for any "repayment of a provider-specific tax that can be considered applicable to the Medicaid program. In other words, whenever there is a linkage intentional or unintentional, in the payment to the provider and the tax program, federal matching funds will be disallowed.

Again, denying Federal Medicaid matching funds in the case of linkages was NOT discussed during our negotiations and was NOT included in the statutory language or manager's statements.

Mr. Chairman, the State of Florida has received repeated assurances that it is the "model program" for purposes of drafting a regulation and for negotiations. Despite this, according to Florida's Governor Lawton Chiles, the State still can not

fully determine how it will be effected by the rule due to its ambiguity. That is why I cosponsored the Waxman/McConnell moratorium bill. ask unanimous consent that a letter from Governor Chiles be inserted in the RECORD.

I want to comment briefly on three provisions of the clarification rule which would negatively effect Florida. It appears that Florida may no longer receive Federal matching funds for:

(1) placing state employees in provider's facilities for eligibility determination and requiring providers to reimburse the state for salaries;

(2) county taxes transferred to the Medicaid program where counties are in fact health care providers (all counties in Florida own health departments who are Medicaid providers); and

(3) percentage of net revenues which are Medicaid revenues.

Using Medicaid revenues as a part of the basis for computing a tax could be considered a linkage. A disproportionate share hospital, which by definition provides a greater percentage of indigent care than other hospitals, would be penalized for unintentional linkages which occur due to rate of taxation versus Medicaid reimbursement.

In Florida we tax all provider's net revenues at exactly the same rate.

If the above three components were prohibited, Florida could lose $255 million in Federal financial participation. In the past, I have testified before the Finance Committee and spoken on the Senate floor about the integrity and importance of Florida's tax program, which has been in place since 1984.

Again, I state that Florida's across the board tax was implemented to level the playing field in the State where a small percentage of providers supplied the bulk of the indigent care.

Mr. Chairman, the regulations or a negotiated compromise should be consistent with OBRA 90. If this can not be achieved, then the Waxman/McConnell bill should be passed to create another moratorium and allow us enough time to craft an acceptable solution. Ideally, we still can come to a compromise before Congress adjourns.

Attachment.

THE GOVERNOR OF THE STATE OF FLORIDA,
November 19, 1991.

Hon. BOB GRAHAM,
241 Dirksen Senate Office Building,
Washington, DC.

Dear Bob:

This morning, the Senate Finance Committee will consider legislation (S. 1886) which would extend the moratorium on the implementation of a federal regulation restricting the states' use of provider-specific taxes, intergovernmental transfers, and voluntary contributions in financing their Medicaid programs. I believe this legislation will significantly benefit Floridians most in need of medical assistance.

On September 12, 1991, the Health Care Financing Administration (HCFA) issued an interim final regulation on these financing mechanisms. Ambiguity in the regulation forced HCFA to rewrite the rule on October 29, 1991. However, this "clarifying" regulation has failed to clarify for me how it would apply to Florida's Medicaid program. We have received conflicting information from federal officials on their intent and have been unable to secure written confirmation of how our program would fare. Also, it is my understanding that an October 23 Florida Congressional Delegation letter to the HCFA Administrator echoing similar concerns has gone unanswered.

This regulation could potentially cost the Florida Medicaid program $250 million in federal matching funds. Specifically, we would be unable to tax a provider's stab and federal Medicaid revenues, the States indirect costs for outposted state eligibility workers would likely be disallowed for federal matching funds, and our county intergovernmental transfer program, which has been in effect since the mid-1970's, could be prohibited.

As you are aware, Florida is now confronted with a $622 million revenue shortfall in our current budget. I have called a special session of the Legislature to make the painful cuts necessary to balance the budget as required by Florida's Constitution. Our current level of appropriations is contingent upon the receipt of federal Medicaid revenues for which we have already budgeted. Any loss of federal Medicaid revenues at this time, regardless of size, will exacerbate the State's critical budget condition.

Nearly 30% of the budget cuts I am recommending would occur in health and human services programs. Florida's Medicaid program will shoulder 70% of the total reduction in the Department of Health and Rehabilitative Services. As you know, the primary recipients of Medicaid services are low-income senior citizens, pregnant women, children, and the disabled. Should this regulation take effect as scheduled on January 1, 1992, services to these needy individuals will be further curtailed.

I recognize the need for Congress, the states, and the Administration to negotiate a permanent solution to this dilemma and have been a participant in such negotiations. I believe S. 1886 will provide all parties with the additional time necessary to reach a consensus on this issue, and prevent Florida from being forced to make even deeper cuts in services to its most vulnerable citizens.

Bob, I appreciate your leadership in the Senate on this issue and your cosponsorship of this legislation. If you have any questions or need further information, please feel free to contact me or Bob Rogan in the Florida Washington Office at (202)624–5885.

With warm regards, I am

Sincerely,

LAWTON CHILES.

PREPARED STATEMENT OF RANDALL L. O'DONNELL

Mr. Chairman, I am Randall L. O'Donnell, Chief Executive Officer of Arkansas Children's Hospital in Little Rock, Arkansas, and I am a Trustee of NACHRI—the National Association of Children's Hospitals and Related Institutions. On behalf of NACHRI, thank you for the opportunity to testify today.

My testimony is guided by the children's hospitals' mission of service to the children of their communities and our extensive experience in caring for children who depend upon Medicaid for access to health care. On average nationwide in 1990, an acute care children's hospital devoted nearly 40% of its care to children with Medicaid assistance, and that percentage is growing. However, Medicaid reimbursed the hospital an average of only 72 cents for every dollar of cost it incurred to care for a patient. I am not speaking about a percent of billed charges; I am speaking about 72% of the cost of care.

In 1990, Arkansas Children's Hospital devoted 50% of its care to children assisted by Medicaid. We received less than 85 cents for every dollar of cost incurred to care for these children. Clearly, that discrepancy in reimbursement for service is not sustainable in the long run. In addition to these inpatients, we are caring for a greater and constantly increasing number of children through our outpatient clinics. We strongly believe it is better for the child emotionally, as well as being more cost efficient, to avoid an overnight stay in the hospital. However, Medicaid reimbursement for outpatient care provides an even lower percentage of recovery.

The Medicaid patients of children's hospitals are at the center of the debate concerning the Health Care Financing Administration's (HCFA) plans to severely restrict the ability of states to finance Medicaid.

The debate may be over technical and legal issues: financing mechanisms, state's rights, federal budget responsibility, and Congressional intent. But the impact of this debate's conclusion will be felt first in the lives of the children and pregnant women who make up two-thirds of all Medicaid beneficiaries in this country. It also will be felt by the hospitals such as ours on whose care these children's lives literally depend. Because virtually all children's hospitals serve a "disproportionate share" of Medicaid patients in their states, our hospitals are especially vulnerable to changes in Medicaid payment policy.

More than 80% of NACHRI's member hospitals are located in states whose Medicaid programs are sustained in part by the use of Medicaid donations, taxes, or intergovernmental transfers to raise federal matching funds. For example, last summer the State of Arkansas implemented a tax on the state share of Medicaid revenues received by all health care providers.

With these tax revenues and the federal matching funds they generate, the State of Arkansas is able—at a time of enormous economic difficulty—to fulfill the Medicaid expansions for children, which Congress has enacted with the leadership of your committee. With these funds, we also are able to have a Medically Needy Program, which helps the working poor and middle class who have catastrophic medical bills. For example, under Arkansas' Medicaid program now, a four-year-old with a brain tumor who comes to our hospital will be covered by Medicaid even if his family of 3 makes more than $14,808 a year.

Arkansas' tax was developed with the broad support of the provider community and child advocates, Republican and Democratic members of the state legislature, and the Governor. The state also worked in close consultation with HCFA regional staff to ensure that our tax would comply with the law, because the State knew HCFA was in the process of drafting its regulation to disallow provider taxes and donations.

The fact is, HCFA took more than a year to write its regulation, which completely changed the rules of the game by reinterpreting 1990 federal law. Then the agency withdrew its September 12 regulation, before all public comments had been submitted, and issued a revised version only two and a half weeks ago.

This revised rule still is open to differing interpretations, despite the fact that it will take effect automatically on January 1. The rule's implementation will force many states to abandon their current Medicaid financing or restructure it completely. The rule will leave other states, such as our own, totally confused, without any written determination of what policy changes, if any, the state will have to make.

In recent weeks, the staff of the National Governors' Association (NGA), and the Administration have worked around the clock to try to reach a compromise on their own, sorting through the many technical issues encompassed in the HCFA regulation. However, the scope of their compromise effort goes well beyond the regulation to include major changes in disproportionate share payment policy, too. This involves policy matters that go to the very heart of the ability of children's hospitals to care for the growing numbers of indigent patients they see.

The issues involved, and the tentative agreement the NGA and Administration staff have developed, are very complicated. They were developed without the participation of the affected community—either provider or consumer. They were reached under tremendous pressures of time and budget. It is virtually impossible to assess accurately the impact of such a compromise agreement—especially when we have only a few days to do so and no technical legislative language to review. My own Governor in Arkansas did not support the tentative agreement he received from NGA's staff last week.

Mr. Chairman, the children's hospitals are enormously grateful for the personal leadership you have given to improve Medicaid assistance for children, and we support strongly your call upon the Administration to withdraw its October 31 rule. We also support strongly the legislation of Senator Mitch McConnell to impose a year's moratorium on the issuance of the regulation. I know my colleagues with the children's hospitals in Texas appreciated the opportunity you gave them last week to discuss with you personally their support for your efforts and the McConnell bill.

Mr. Chairman, we understand that there are significant technical issues at play involving the requirements of the Budget Enforcement Act, which make enactment of moratorium legislation a difficult task.

It does not matter to our patients or our ability to serve them whether the rule's implementation is delayed by legislative moratorium or short-term administrative withdrawal. But it is essential that Congress, before it recesses, take action both to prevent the HCFA rule from taking effect on January 1, and to ensure that Congress will have the opportunity to pursue the normal legislative process needed to develop a responsible compromise on this sensitive issue.

It is in no one's interest to see action on this issue delayed again without promise of conclusion. But certainly it is not in the interest of the 12 million children nationwide—and the 163,000 children in Arkansas who now depend on Medicaid—to have Congress permit HCFA to implement its rule or to have Congress enact in haste major policy changes so fundamental to children's needs and the sustainability of children's hospitals' service to them.

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Prepared Statement of Alicia Pelrine

Good morning Mr. Chairman and members of the committee. I appreciate the opportunity to be here today to testify with Governor Richards on an issue of immediate and critical concern to the nation's Governors -- the urgent need for legislative action to stop the implementation of interim final regulations affecting state Medicaid revenue raising practices. The regulations are scheduled to take effect on January 1st.

The Regulations

On September 12, 1991, the Department of Health and Human Services (HHS) issued interim final regulations to restrict how states raise revenue for their Medicaid programs. The regulations -- intended to clarify the intent of provider-based tax provisions contained in the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) -- are not only vague and ambiguous, but place severe and unjustifiable restrictions on the states' use of revenue raised through provider-based taxes, donations, and intergovernmental transfers.

In response to numerous criticisms leveled by Congress and the states, on October 31, 1991, HHS issued clarifying regulations to supplant the September 12 rule. The clarifications, however, did not provide the clarity Congress or the states requested.

Like the previous rule, the new regulations appear to overstep HHS regulatory authority in interpreting OBRA 1990. Additionally, important questions remain unanswered. For example, it is not clear how intergovernmental transfers, a longstanding and acceptable transfer of revenue between state and local governments, would be treated under the rule.

Complicating the process further, rather than extending the implementation date beyond January 1, 1992, HHS proposed to make state-by-state determinations of compliance based on a lengthy application process. Without providing states clear guidance, the proposed process would leave states vulnerable to potentially unfair arbitrary and inconsistent rulings.

The Need for a Solution

Mr. Chairman, the pending implementation of the interim final regulation puts states in an untenable situation. States simply cannot be expected to comply with unclear, and arguably illegal, regulations by January 1, 1992, or submit to a microanalysis of state Medicaid program reimbursements and revenue collection methods. Further, these regulations are scheduled to take effect just two months after publication, when most state legislatures are not in session.

Currently more than 30 states use provider-based taxes or donations to help meet the state share of Medicaid expenditures. These funds have enabled states to increase payments to hospitals that serve a disproportionate number of poor patients, expand access to pregnant women and children, and conduct outreach efforts. All are priority initiatives that were expressly encouraged -- and in some cases mandated -- by Congress. As states have suffered the effects of economic downturns in the economy, they have turned to nontraditional revenue sources such as provider taxes to avoid undesirable program cuts and to make important expansions. Without the continued ability to draw on such revenue sources, states will have no option but to make severe program cuts.

The Status of Negotiations

To prevent the disruption of state budget and severe program cuts, the Governors are actively negotiating with Congress and the Administration to reach a compromise agreement. It is our goal to ensure that states have clear guidance on federal policy for the Medicaid program.

Although the Governors maintain it is within the purview of state government to determine appropriate revenue raising methods, they have come to the negotiating table prepared to make significant concessions to resolve these issues as soon as possible and to protect state Medicaid programs.

The Governors came to the negotiating table prepared to:

1. Discuss significant limitations on the use on donated funds, with the exception of administrative donations for eligibility processing and outreach, charitable donations, and intergovernmental transfers;

2. Define what constitutes an acceptable provider-specific tax;

3. Negotiate a limit on the amount of revenue a state could raise through a provider-specific tax;

4. Provide assurances that the states would not negotiate "hold harmless" arrangements with providers paying the tax; and

5. Discuss payment limits to disproportionate share hospitals to address the Administration's concern that no limit exists today.

In exchange, the Governors seek appropriate transition time for states to change current laws -- including states with biennial budgets, phase-down provisions for states that currently raise revenue through taxes or donations in excess of an agreed upon limit, protection from federal matching fund denials based on the "expenditure theory," and protection from retroactive sanctions.

We are committed to reaching a compromise with the Administration and Congress, but are legitimately concerned that Congress may adjourn before a compromise can be reached or acted upon. While the NGA negotiations with the Administration are positive, many unresolved issues remain. Time is running out. In the absence of an agreement and time to enact it, the Governors strongly urge the committee to consider a moratorium on regulations affecting provider-based taxes and donated funds. This would allow negotiations to proceed without throwing Medicaid programs and state budgets across the country into chaos.

Thank you for the opportunity to present the Governors' views on this important matter. I will be happy to answer any questions.

Prepared Statement of Senator David Pryor

Mr. Chairman, I would like to publicly thank you for holding this morning's hearing. The Medicaid provider donation and tax issue is one of paramount importance to many states represented on this Committee. Arkansas is certainly no exception.

We are all aware of the enormous burden States must bear in keeping their Medicaid programs operational. New Medicaid mandates, coupled with the recession, have further overloaded the program. In Arkansas, there are slightly more than 200,000 Medicaid recipients, yet Medicaid mandates over the past four years have added an estimated $80 million to the total Medicaid budget of $600 million. States such as Arkansas have explored alternative sources of funds to pay for their Medicaid programs as a matter of necessity.

In the Spring of this year, the Arkansas State Legislature passed legislation that requires all Medicaid providers to pay a 15 percent tax on the Medicaid payments they receive from the State. Revenues from this tax will not replace the State's Medicaid general revenue obligation. In fact, the $30 million the tax raises will represent less than 20 percent of the State's portion of its Medicaid expenditures. Despite amounting to less than one-fifth of the State's Medicaid budget, there is no question that these revenues are absolutely essential to the State's ability to finance the growing Medicaid cost burden.

Last year, during negotiations on the 1990 budget agreement, we thought we had put the Medicaid provider donation and tax issue to rest. We thought we had agreed upon a compromise that was acceptable to the Administration and the States.

Following enactment of the compromise, there was no question in my mind—nor in the minds of Governor Clinton, our State Legislature, and our health care providers—that the State's new provider tax financing mechanism was legal and completely consistent with the intent of the Federal statute. Then, the Health Care Fi-

nancing Administration started to interpret the legislation in a manner absolutely inconsistent with what most of us felt was enacted.

In releasing their regulation, HCFA was attempting to stop what it considered State-initiated fund-raising abuses. I will be the first to acknowledge that there may be States who in the past, or currently, have implemented financing mechanisms that may be inconsistent with the intent of the law. The problem is that HCFA's net pulls in almost everyone and, in so doing, unfairly threatens the ability of Arkansas to fund its Medicaid program.

Today, we will hear Senator Graham recount how the OBRA Medicaid financing deal was struck. His memory is extremely important because he negotiated the deal directly with Gail Wilensky. I know because I witnessed these negotiations as one of three Finance Committee representatives on the Medicaid subconference committee. But beyond memories of conversations and negotiations, the statutory language is clear and is being subjected to an extremely flawed interpretation by HCFA.

States, and many of us in the Senate, feel as though we are being held hostage to the Administration's interpretation. OMB now contends that the enactment of a moratorium of their regulation will cost billions of dollars. It remains a mystery to me how a moratorium of a regulation that has yet to be implemented can cost billions of dollars. But those are the rules the OMB is forcing us to live with.

Today's hearing will produce many charges and counter-charges. I may well join the fray because there is, once again, no doubt in my mind that the Arkansas' program is in compliance with the letter and the intent of the law. Having said that, I also believe it is long past time for us to develop an acceptable solution to the problem we face.

Governor Clinton has already and repeatedly signaled his willingness to help forge an agreement between the States and the Administration on this issue. He and I just want to make sure that we are met at least half way in this effort.

Our nation relies on the ability of the Medicaid program to provide health care to indigent Americans; it is therefore imperative that Federal policy support States in their efforts to develop reasonable methods that generate much needed funds. It is my hope that this hearing will help clear up the controversy surrounding the provider tax and donation issue.

I look forward to hearing from and reviewing the testimony of our distinguished witnesses, particularly the comments given by a highly regarded constituent of mine—Randall L. O'Donnell. Dr. O'Donnell is the CEO of the Arkansas Children's Hospital in Little Rock, and it is indeed a pleasure to see him coming before us this morning.

Prepared Statement of Governor Ann W. Richards

Mr. Chairman, Members of the Committee:

I appreciate this opportunity to address the committee about Texas' concerns regarding HCFA's proposed rule changes for Medicaid funding to the states.

You and I know that the debate over these rules is the result of the collision of an immovable object and an irresistible force.

The immovable object is a federal budget is constricted by debt and the budget agreement.

The irresistible force is a national demand for access to health care that rises not from the political parties or the interest groups ... but from the real lives of individuals and businesses who are being bankrupted by a health care system that lavishes care on those who can pay, provides the basics to the poorest of the poor, and leaves the majority of us worried that we cannot afford the cost of good health.

The old highwayman's demand, "your money or your life," has taken on a whole new meaning in America today.

So while we are up here discussing funding formulas and tossing around acronyms like HCFA and OMB and DISPRO one, two and three -- and all the rest of the alphabet soup that government has become .... normal people can be forgiven if it all looks like just another endless discussion about how many angels can dance on the head of some bureaucrat's ball point pen.

We in the states share that frustration.

In 1965, the federal government took the first tentative steps toward a national health care policy with the creation of Medicare and Medicaid.

Over the years, those programs have grown in complexity, expanding the bureaucracy and the regulations involved.

As the states have taken on a larger role, we have had to depend on the federal government to act in a cooperative way.

We have done our damndest to comply with the regulations, to do what you tell us to do.

In Texas, our spending for Medicaid in 1984 was 691 million dollars.

The best estimates tell us that within the next two years, our share of that cost will be two and a half billion.

We are committed to finding that money and funding our fair share of the program.

But now we are told that what we have done with the latest round of regulations doesn't fit into preconceived notions at OMB. -- and therefore, the rules are going to be changed after the fact.

If the new rules go into effect, Texas hospitals that carry the heaviest load of uncompensated health care will lose almost a billion dollars in disproportionate share funding in this biennium.

I don't want to be difficult in suggesting to you that this action is tremendously unfair and ill-timed.

I certainly don't want to think that there is an attempt to renege on a commitment to the states .... but that is how it appears.

I am not suggesting that these proposed rule changes will cut the heart out of our state budgets ... but they will break the hearts of real live human beings who need the care that would have been provided under the existing rules and who are counting on their government to live up to its obligations.

The young family that experiences a job change and a lapse in benefits because Mother's pregnancy is not covered as a pre-existing condition ... the mother who can't meet the cost of the insurance co-payment to pay for her child's hospitalization ...the grandfather who lost his job, can't pay for glaucoma treatment and is facing the choice of blindness or exhausting his children's savings: these are the people who will be affected by the rules changes ... they and the hospitals that will be asked to absorb the cost of their care -- that will face the choice of turning people away or threatening their own financial existence.

We all know the numbers.

There are thirty seven million Americans with no health care coverage of any kind.

Four million of them are in Texas .... and half of them are working at full time jobs.

I am not suggesting that any member of this Congress is not deeply concerned about these people.

But I will point out that nowhere in these rules changes or policy initiatives do we find the word "patient;" nowhere do we talk about people.

And when we get caught up in one more round of tinkering on the margins of the formulas, it can seem to people that not only have we lost sight of them, we have taken leave of our senses.

The fact of the matter, gentlemen, is that we all have the same taxpayers.

Those taxpayers do not especially care whether the money comes from your budget or our budget, they just know it comes out of their pocket ... and those pockets are empty.

And I think those same taxpayers are going to have a lot of trouble figuring out how the federal government can spend one trillion, four hundred and ninety-one billion, five hundred and sixty-three million dollars a year -- can in fact have an annual deficit larger than the combined budgets of all 50 states -- and can then turn to the states and accuse them of using financial skulduggery to raid the federal budget to pay for the one thing everyone agrees we need -- which is decent health care.

If that is skullduggery, I think you will find a lot of voters who believe it is preferable to what passes as government these days.

But I firmly believe that every member of this committee wants to do what is best for this country and to deal with the states in good faith.

To get us past this immediate problem, I urge you to support legislation that includes three basic principles:

Number one, we must have a system that allows the states to determine our own method of intergovernmental transfers.

We in Texas do not have a statewide hospital tax; we raise our revenues through local hospital districts.

And the local taxpayers are contributing more than a fair share.

The Parkland Hospital District in Dallas, for instance, has raised its ad velorum taxes 27% in the last two years. Houston taxpayers have experienced a similar rate of increase.

These local taxpayers have a right to a federal support for their tax effort.

Number two, we do not want another open-ended federal spending program any more than you do; we understand that you may need to cap the amount that you send to the states for the disproportionate share program.

But if you are going to put a cap on, you must give us the flexibility to spend the money in the way that works best in our state.

Combining caps with strict, one-size-fits-all restrictions is a prescription for the failure of the limited health care programs we have.

Number three, we must have a provision that requires rules made will stay in place for our complete budget cycle.

Changing the rules after the states have constructed their budgets is like throwing gasoline on the flames of the public perception that government can't get its act together and can't stick with anything long enough to make it work.

And such changes throw state governments into chaos, requiring special sessions where the outcome is dubious at best.

The bottom line is that we need a permanent legislative solution .... but if we cannot get it in the short time before the Thanksgiving recess, we need a veto-proof moratorium.

I appreciate the time you have given me today ... and I will glad to answer any questions that you have.

Prepared Statement of Senator John D. Rockefeller IV

First, I would like to thank Chairman Bentsen for holding this very important hearing this morning, and for his leadership on this particular issue and other extremely critical health issues. While it is extremely late in the year, I very much hope that we can reach some type of resolution on this before Congress adjourns.

The regulations issued by the Health Care Financing Administration this past September, and HCFA's subsequent clarification, clearly go far beyond what was originally intended by legislation included in last year's reconciliation bill. As a conferee involved in those negotiations, I can positively attest to Congressional intent. The final legislation that was enacted by Congress, and signed by the President, *very plainly* stated that provider taxes *would be allowed* except in a *very limited* circumstance.

The Bush Administration has labeled state efforts to finance portions of their Medicaid programs through voluntary donations or provider-specific taxes as scams and schemes. While I certainly would prefer Medicaid financing to be more stable and secure, I can not, and do not, fault the states for trying to figure out ways to provide vital health care services to its most vulnerable residents.

Owing to health care inflation and to the recession which has increesed the number of families eligible for Medicaid, states are seeing more and more of their dollars being eaten up by the Medicaid program. Last year, Medicaid accounted for about 14% of total state spending; after Medicaid spending increased by 18% from the previous year. By 1995, states will be spending up to 22% of their total budgets on Medicaid.

Today's hearing is symbolic of a much bigger problem. Thirty-three million Americans—one-third of them children—lack basic health care coverage. Who is going to pay to make sure every American has basic health coverage? Who should have that responsibility? Individual families? Should businesses provide coverage to its workers, much like it provides a minimum wage? Or should government pay for the care of all Americans? This country is currently engaged in a very dangerous game of hot potato—trying to shift costs from one payer to another. In reality, we all end up paying for those who forgo medical care because they can't afford it, or because they can't find a doctor who will see a Medicaid patient because of lousy reimbursement rates.

The Bush Administration claims that allowing states to tax health care providers, or allowing hospitals to donate funds, fundamentally alters the traditional federal-state matching formula under the Medicaid program. I say, these are not traditional times.

I have heard Bush Administration officials say that if the states want to fundamentally alter the formula used in calculating federal matching payments, or to fundamentally change the current Medicaid program, then they ought to come in and sit down with the Administration and discuss those types of reform. I hope that is an invitation for serious discussion of health care reform. In fact, I have a few ideas of my own for reform and would gladly sit down at that table.

In the meantime, the regulations issued by HCFA would result in more women going without prenatal care, more babies missing out on critical check-ups, and more children failing to see a doctor for an ear infection or sore throat. Any short term savings that might be achieved through these regulations will only end up as substantial costs in the long run.

Ultimately, some type of agreement or accommodation between Congress, the States and the Administration must be reached. But we don't have much time left. If everyone here today refuses to budge, deadlock will continue, and we will all suffer, especially our children.

Prepared Statement of Sara Rosenbaum

Mr. Chairman and Members of the Committee:

The Children's Defense Fund appreciates the opportunity to testify before you today at this critical hearing regarding regulations issued on September 12, 1991 (56 Fed. Reg. 46380). These regulations set forth the conditions under which states may claim that they have made "expenditures' for purposes of federal financial participation (FFP) in their Medicaid programs. Put most simply, the rules would declare unlawful, for FFP purposes, more than a quarter century of permissible state expenditures under the statute. The impact of the rules would be most directly felt by women and children, who comprise two-thirds of program beneficiaries and who frequently are the most dependent on the types of activities and services supported with special taxes, donations, and governmental transfers.

The first portion of our testimony presents a series of case studies of the types of maternal and child health services and activities supported in whole or in part by Medicaid funds claimed through the governmental transfer process. The remainder of our testimony analyzes the impact of the draft compromise negotiated by the Administration and the National Governors Association.

Introduction

No Medicaid beneficiaries will be more adversely affected by the interim final rules promulgated by the United States Department of Health and Human Services than children and pregnant women. Children are the poorest Americans. Today more than 13 million children -- one in five children, one in four children under age 6, one in three Latino children and children in young families (headed by a person under age 30), and nearly one in two black children -- are poor.

Poverty significantly reduces the likelihood of private insurance coverage and, in the case of children and women of childbearing age, substantially increases dependence on Medicaid coverage. Only about two-thirds of all American children have health insurance coverage through employer plans, and only 20 percent of all poor children have such coverage. The number of privately insured children has eroded significantly over the past decade as child poverty has risen and as employers have reduced their contributions to employees' family insurance coverage.

Over 12 million American children are now covered by Medicaid. Medicaid pays for one in four births annually; in some states the proportion of Medicaid-financed related births exceeds 40 percent. As Medicaid is phased in to cover all poor children under age 19, as states increasingly expand Medicaid maternity programs to cover all pregnant women with family incomes below 185 percent of the federal poverty level, as childhood poverty rates remain high and children's private health insurance coverage erodes, Medicaid's importance to children will grow further. The 1989 White House Task Force on Infant Mortality, which recommended major expansions of Medicaid, noted that approximately half of all U.S. births are to women with family incomes below 200 percent of the federal poverty level. In light of Medicaid's expansions, this means that the program conceivably could finance half of all U.S. births as states extend coverage to all near-poor pregnant women.

Beyond the threshold issue of eligibility is the issue of coverage. Medicaid now finances an extraordinarily broad array of services for women and children, from prenatal care and hospital deliveries to preventive health services, childhood immunizations, vision, dental and hearing care, services for children with physical, mental and developmental disabilities and delays, health services for children with education-related disabilities, treatment for such severe conditions as lead poisoning, retardation, severe mental illness, profound physical disability arising from low birth weight and congenital birth-related disabilities, and other life and health threatening conditions and illnesses.

Because of the severe geographic isolation of millions of poor children and low provider Medicaid acceptance rates, a significant

proportion of all maternal and child health care is delivered through publicly financed providers and institutions such as public health clinics, public hospitals, school health programs, publicly funded community health centers, and public institutions for children with retardation and mental illness. Many of these providers are supported with state, county and city appropriations and special revenues. The proportion of their budgets allocated to the care and treatment of Medicaid-enrolled pregnant women and children is, under current regulations, attributed to state Medicaid budgets via a device known as governmental transfers.

Under this governmental transfer arrangement, Medicaid agencies report as state expenditures those state and local public health expenditures attributable to the care of Medicaid enrolled pregnant women and children. These expenditures are in turn matched with federal funding. These federal matching expenditures represent anywhere from 50 to 80 percent of total state and local expenditures for these services. The loss of these federal expenditures, particularly in the case of publicly supported health providers that serve an extremely high proportion of Medicaid - enrolled women and children obviously could mean the end of the services themselves.

States and localities allocate public maternal and child health funds to state and local health service agencies rather than directly to their state Medicaid budgets (to be paid out in the form of third party reimbursement) for several reasons. First, this method for distributing public health expenditures preserves and protects a portion of state and local budgets for ambulatory maternal and child health services. With state Medicaid programs as overwhelmed as they are by the cost of institutional services there is a significant likelihood that funds allocated directly to state Medicaid budgets will be consumed by institutional costs and no longer available for such primary and preventive health services as prenatal care, childhood immunizations, and other exceedingly essential but low cost care and services. As the cost of institutional care has escalated (particularly in response to Boren Amendment litigation to enforce reasonable cost payment standards) there is a danger that ambulatory services will be increasingly suppressed in order to accommodate the payment pressures caused by the high volume of institutional care funded by Medicaid.

Second, public health agencies and publicly financed providers and institutions frequently do not have sophisticated third party billing operations. They lack both the personnel and resources to aggressively pursue Medicaid repayment. As a result, many states have set up simplified cost-allocation billing arrangements under which expenditures on behalf of Medicaid recipients are apportioned and reported directly to state Medicaid agencies. This cost allocation system greatly simplifies Medicaid reimbursement tasks and relieves hard-pressed clinic staff from billing responsibilities.

Third, by allocating public health expenditures directly to public agencies and providers that perform services for Medicaid recipients, states and localities can assure uniformity of standards and the collection of important maternal and child health data not routinely collected by state Medicaid agencies. Finally, by directly budgeting public maternal and child health expenditures to agencies that perform services, these agencies are assured of a working budget and ongoing cash flow and minimize the delays in services that would result from delayed Medicaid payments -- a not uncommon phenomenon.

These intergovernmental expenditure and transfer arrangements lie at the heart of virtually every state's publicly financed health system. They are so common that it is virtually impossible to quantify the extent of their existence. Indeed, the tendency of states to spread their state and local public health expenditures throughout their entire public health system has historically been so common that from its inception, the Medicaid statute has codified the validity of these arrangements.

Section 1902(a)(2) of the Act expressly authorizes states to generate up to 60 percent of their non-federal expenditures for Medicaid from sources other than state funds, thereby permitting state agencies to include, as state expenditures, public expenditures made by general and special purpose units of local

government such as counties, county health agencies, county and city public hospitals, and health programs administered by county school districts. Section 1902(a)(11) authorizes special agreements between state Medicaid programs and state public health and other state agencies, through which expenditures on behalf of Medicaid recipients made by these agencies are attributed back to the Medicaid program and the agencies in turn are eligible for payment on a reasonable cost basis for the Medicaid covered care and services they either furnish or arrange. So long as the care and services are covered under the state Medicaid plan and are furnished in accordance with applicable Medicaid standards to eligible persons, the activities qualify for reimbursement under this intra and inter-governmental transfer arrangement. Examples of services commonly funded through these special public agency transfer arrangements are Early and Periodic Screening Diagnosis and Treatment services (the primary and preventive health program for all Medicaid enrolled children under age 21, whose major providers includes state and local health departments), prenatal clinics, specialty clinics run by local and state health agencies for children with special health care needs, and childhood immunization programs.

The Department's Regulations

The Department's regulations are extraordinarily sweeping. They go far beyond any reasonable effort to curb unlawful taxes or donations and virtually eviscerate states' governmental transfer arrangements. In our opinion the regulations constitute a direct violation of the Medicaid statute and evidence the Administration's complete lack of understanding of how states and localities make public health expenditures. To the extent that the Administration deliberately intended the standards now embodied in these rules (and its assertion of its intent to eliminate FFP for governmental transfers is underscored in the Preamble to the rules, 56 Fed Reg 46383[1]), either it has chosen to ignore, or is utterly incapable of accurately interpreting, the Medicaid statute.

In the more than 25 years since the program's inception it is difficult to recall a more extraordinary rule. Regardless of the Administration's intent, the effect is the same: the complete undoing of countless state and local public health service delivery arrangements that constitute the health care lifeline for millions of poor and medically underserved women and children and that survive on a combination of Medicaid revenues and other scarce sources of grant funds. If the Department had simply declared publicly funded health activities unlawful, the impact would hardly have been greater.

The new regulation is deceptively simple in structure. In essence the rule prohibits federal financial participation in the case of voluntary transfers from health care providers to the state agency. The term "health care provider" is defined in the rule as

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[1] The Preamble states as follows:

"Several commenters asked if HCFA inadvertently omitted the material in the current §433.45(a)[authorizing intergovernmental transfers], which outlines when public funds may be used as the State share.... Neither the proposed rule nor this interim final rule precludes States from receiving provider donations or other voluntary payments. However, in both the proposed rule and this interim final rule, we intentionally revised [the intergovernmental transfer regulation] to describe how a State's net expenditure for medical assistance is calculated in the presence of provider donations, tax revenues or other payments made directly or indirectly to the state, County or any other governmental instrumentality from, or on behalf of , health care providers. Section 433.45(d) will apply equally to all types of provider donations or voluntary payments, both public and private, and will offset any monies received. (emphasis added)

"Medicaid providers" 42 CFR §433.45(a). No distinction is drawn between private providers and those providers that also are either state or local agencies or public health instrumentalities. No definition of "voluntary transfer" is given.

The rule simply states that "When calculating State expenditures that are claimable for federal matching as medical assistance, HCFA subtracts from nominal state expenditures... the amount of any revenue to the State generated by health care providers when that revenue results from either donations of other voluntary payments made to the State, county or any other governmental instrumentality." 42 CFR §433.45(c) **[emphasis added]** Thus, if any "Medicaid provider" makes any "voluntary transfer" to the state either itself or through a county or any other governmental instrumentality, the transfer does not qualify for FFP.

Illustrative Examples of the Impact of the Rules

In order to more fully convey the import of these rules, we have prepared a series of illustrative case studies drawn from actual state and local public health programs that drive home their meaning.

Utah

Program overview:

For several years the Utah health department and Medicaid agencies have collaborated on a major Medicaid initiative to improve the health of pregnant women and infants. The initiative includes expanded Medicaid eligibility to cover all pregnant women and infants with incomes below 133 percent of the federal poverty level and waiver of the asset requirement; outstationed and presumptive eligibility to assure swift enrollment into coverage; comprehensive services including medical care, home visiting, nutrition, social services and education furnished by health department personnel and providers working with the state health agency; follow-up services for pregnant women and infants and a massive statewide outreach campaign.

According to state health and Medicaid officials, the results have been impressive: a significant drop in infant mortality for the first time in several years with sustained progress being noted in current statistics, an increase in public awareness regarding the importance of maternity care, and very high penetration into the poverty population with the program. Indeed, even at only 133% of poverty, the Utah Medicaid program is now financing nearly one-third of all deliveries annually.

The program was initiated via an inter-title transfer of appropriated funds from the state health agency to the state Medicaid agency. These state maternal and child health funds, once transferred at the health agency's initiative to the Medicaid program, helped offset the considerable cost of the new program.

Impact of the HCFA rule:

Under the HCFA rule, the transfer made to the state Medicaid agency by the health department would constitute a voluntary transfer made to the state [by the state health agency] by or on behalf of health providers [in this case local health agency personnel or state health agency personnel themselves or their employees or contractors]. As such the revenues generated by the transfer would not qualify for federal financial participation under 42 CFR §433.45 (c). Nothing in the rule's definition of health provider or voluntary transfer exempts state health agencies that spend state-appropriated health funds on covered services to Medicaid enrolled patients.

Had the transfer not qualified for FFP, 4000 fewer women would have been served. Given the high proportion to of Medicaid births in the state, it is not unlikely that the significant reductions in infant mortality similarly would not have occurred. Given the elevated mortality patterns among poor infants and the resulting vital role played by Medicaid under this initiative in reducing infant mortality, the state's loss would undoubtedly have had adverse health consequences.

Illinois

Program overview:

Earlier this year, Illinois created a new intergovernmental funding mechanism under Medicaid to reimburse local school districts for medical services provided to poor children with handicaps and other special education needs. The mechanism will greatly expand resources available to serve children with special educational needs, since half of all special education students in Illinois are either enrolled in Medicaid or Medicaid-eligible. In the first year, at least $10 million in combined state and federal Medicaid funds will flow to local school systems under the plan.

Under voluntary cooperative agreements between local school districts and the Illinois Department of Public Aid, schools will report the number of Medicaid-eligible children in their special education programs, and will identify those Medicaid-earned services provided to disabled children. That portion of service costs attributable to serving Medicaid children will be reported to the Illinois Department of Public Aid (the state Medicaid agency). IDPA determines which services provided by the schools are eligible for reimbursement under the state's Healthy Kids program (Illinois' EPSDT program) and certifies to the Health Care Financing Administration that funds have been expended by local school districts on Medicaid services for Medicaid-covered children. These funds qualify for federal financial participation under current 42 CFR §433.45. Federal matching funds are then transferred to the State Board of Education and passed along to the local school districts. The $10 million in Medicaid funds furnished to the schools will enable them to serve thousands of disabled children.

Impact of the HCFA rule: Under the rule, the schools are also providers of care and are voluntarily transferring funds to the state agency. Furthermore, the transfer to the agency would constitute a "voluntary payment... by or on behalf of health providers." 42 CFR § 433.45(c). The school health expenditure thus would not qualify for federal financial participation, even though the state, through its local school districts, is expending millions of dollars of taxpayer funds on Medicaid covered services for Medicaid enrolled children.

New York

Program overview:

The Prenatal Care Assistance Program (PCAP), New York's public maternity program for pregnant women and infants, serves thousands of Medicaid eligible children. Therefore, part of PCAP is outstationed Medicaid eligibility determination and an intergovernmental transfer between the state Health Department (which administers PCAP) and the New York Medicaid agency. PCAP covers all pregnant women who have incomes above 133 percent of poverty but below 185 percent of the federal poverty level. The Department of Health administers PCAP and reimburses health care providers for prenatal, labor, delivery, and postpartum care for pregnant women. Since nearly all the women served by PCAP are eligible for Medicaid, the Department of Health reports these expenditures as state Medicaid expenditures. The Department of Social Service in turn certifies to the Health Care Financing Administration that expenditures through PCAP qualify for federal matching funds. An additional 70,000 pregnant women have been served through this program.

Impact of the HCFA rule:

Under 42 CFR §433.45, the state health department's transfer of PCAP funds to the Medicaid agency would be a "voluntary payment to the state... on behalf of health care providers.? 42 CFR § 433.45. The rule makes clear that the term "payment" can include any voluntary transfer. (42 CFR §433.45 (a)) whether in the form of cash or a budget transaction. Thus, the state apparently will not be able to claim FFP for its public expenditures on behalf of Medicaid-enrolled women simply because the actual expenditures are made by a related agency.

Texas

Program overview:

Parkland Memorial Hospital is the centerpiece of the Dallas County Hospital District. In Texas, hospital districts are both owners of hospitals and taxing entities which levy dedicated local property taxes. Hospital districts play a key role in providing public health care in the Texas, much as health departments do in other states. Since many of Parkland's patients are poor and medically indigent, it is also a major provider of services to Medicaid recipients including ambulatory and inpatient care to tens of thousands of women, infants and children. In a single year Parkland hospital delivers of 10,000 infants.

In order to maximize its resources, the hospital transfers part of its revenue from local property taxes to the state. The transfer is then used by the state to help defray the cost of the hospital's services to its Medicaid enrolled children. The state's hospital district expenditures are incorporated as part of the hospital district expenditures are incorporated as part of the state's overall Medicaid expenditures.

Impact of the HCFA rule:

Because the District might be characterized either as a Medicaid provider or as an entity making payments on behalf of a provider under 42 CFR § 433.45(a). Those hospital revenues generated by the district's payment to the state thus would not qualify for FFP under § 433.45(c).

Parkland Hospital officials have estimated that next year the hospital could lose $38 million in Medicaid funding under the rule. The lost funds would affect some 650,000 outpatient clinic visits and completely destabilize the entire community public health system.

California

Program overview:

Like Illinois, California is developing a major initiative to improve health services for impoverished children who are at risk and disabled. Like Illinois, the state proposes to certify several hundred of its poorest school districts as Medicaid providers. The school districts in turn would develop comprehensive health programs for children. These programs would be broad in nature, offering services ranging from health exams and immunizations to primary pediatric medical, vision, dental, and hearing care and health care and management of poor children with education-related disabilities. That portion of each district's expenditures attributable to enrolled children would be treated as a state Medicaid agency expenditure and certified for federal financial participation.

Impact of the HCFA rule:

For the same reason as in the case of Illinois, these state school health expenditures would no longer qualify for FFP.

Mississippi

Program overview:

The PHRM/ISS (pronounced "Promise") program channels high risk pregnant women and their babies for intensive medical and social services to prevent infant mortality. The program is operated by the Department of Health and the state Medicaid agency certifies the expenditures for federal financial participation. About 2,400 pregnant Medicaid recipients with extreme medical risk factors such as diabetes or very high blood pressure are served by the $2.5 million program -- 80 percent of which comes from federal matching funds. The program provides additional prenatal care visits, closer medical monitoring and testing, and provisions for delivery in appropriate hospitals.

Impact of the HCFA Rule:

As in Utah's case, Mississippi's transfer would constitute an unlawful contribution to the state Medicaid agency by the health

department clinics. Even though the state was engaged in an expenditure on Medicaid eligible women and infants, its spending would not qualify for federal financial participation.

The Draft Administration NGA Agreement

The agreement drafted by the National Governors Association and the administration and submitted to the states for approval on September 13th contains numerous problems which, if not resolved, will cause tremendous harm. The agreement in many respects represents major modification of longstanding Medicaid policy. Such legislation cannot and must not be enacted in haste. It is for this reason that the Administration should now either suspend or withdraw its rule. If the Administration will not do so, then moratorium legislation is absolutely essential.

The agreement is riddled with ambiguities and inconsistencies. This perhaps might be expected given the relative haste with which the negotiators worked. However, resolving these ambiguities may take time, particularly to the extent that the resolution process uncovers continuing areas of disagreement.

More importantly, however, in our opinion the agreement contains the following fundamental flaws:

1. Arbitrary limitations on lawful taxes

The agreement spells out in considerable (and in our view entirely inappropriate detail) the circumstances in which a tax paid by health care providers will be considered "legitimate" for FFP purposes under the statute. The federal government has a clear interest in assuring that taxes are in fact paid to a state or are actually transferred to a state so that the state has real funds to expend on the program. However, the standards for "legitimate" taxes go well beyond what is needed to avoid the use of "phantom" taxes.

Even more alarming, however, is the fact that under the agreement, even if a state devises a taxation arrangement that completely passes muster under the agreement, it is nonetheless prohibited from using this tax to finance many more than 22 percent of the non-federal share of its program. <u>Absolutely nothing in the current statute permits the Secretary to dictate to states the source of their non-federal - share payments. Under Section 1902 of the Act, so long as at least 40 percent of a state's non-federal share comes from state expenditures, the state has satisfied the law. Under current law, therefore, a state could elect to finance 100 percent of its non-federal share from state expenditures derived from fairly imposed and duly collected dedicated taxes.</u>

In fact, virtually no state finances 100 percent of the non-federal share of its Medicaid program from state-collected and appropriated dedicated taxes, much less strictly from dedicated health care provider taxes. But if the statute is to be amended to incorporate a precise definition of permissible taxes and, more importantly, if the law is to be amended to limit the amount of state expenditures that can be derived from even permissible types of taxes, then such a major departure from long-standing Medicaid policy must be carefully weighed by Congress, just as it would carefully weigh any major change in the structure of Medicaid.

We consider the Administration's insistence on limiting the amount of federally matchable revenues derived from provider taxes a thinly-veiled attempt to place off limits to states the one source of revenues sufficiently elastic to support states' escalating Medicaid costs. Obviously something must be done to make health care expenditures for the poor more affordable than they are at present. But that solution is a distance away, since its resolution is inextricably bound up with the broader national health debate. In the meantime, however, it would bea terrible policy decision to prohibit states from using health revenues to meet their indigent care costs.

Given the ERISA preemption of state authority to tax self-funded employer-based health insurance plans, the only means states have of reaching health care revenues is through provider taxation.

To deny state and local governments[2] access to these revenues will immediately harm a number of states who rely on provider taxes to fund more than 22 percent of their non-federal share. In the long run, however, every state and millions of beneficiaries will suffer, as alternative sources of revenues to finance Medicaid expenditures either stagnate or erode. The choice in too many states and communities will come down to Medicaid or eduction, Medicaid or child welfare, Medicaid or day care, Medicaid or housing and meals for the elderly.

2. Limitations on Governmental transfers

The agreement purports to resolve the issue of governmental transfers. Agencies would be authorized to continue certifying their expenditures on behalf of Medicaid beneficiaries as Medicaid expenditures for FFP purposes. However, to the extent that the transfers arise from revenues derived from "illegitimate" taxes, states would receive no FFP. Moreover, to the extent that counties, health departments, or special purpose units of government (such as hospital districts) use revenues derived from "legitimate" taxes, no FFP would be available above the 22 percent cap.

3. Treatment of Disproportionate Share Hospital (DSH) Payments

The agreement would severely limit federal financial participation for payments for DSH providers to no more than 11 percent of all Medicaid payments nationally. Moreover, the draft agreement would prohibit states with low disproportionate share payment levels from adjusting their reimbursement levels upward. Under the agreement, states with higher than average DSH payments (in excess of the 11 percent level) could continue to maintain their higher expenditures for as long as it takes for inflation to catch up with actual payments and reduce them to "allowable" levels. In the meantime, however, the national cap means that states paying less than the 11 percent threshold would be prohibited from adjusting their payments upward, until all states with greater than 11 percent payment levels adjusted their expenditures downward.

No groups of Medicaid beneficiaries are more dependent on public institutional and non-institutional sources of care than children and women. Public hospitals account for a major proportion of all indigent U.S. births, their clinics are part of the primary health care safety net for children, and in many major cities, virtually the only source of such care. Similarly, children's hospitals are one of the most important sources of quality inpatient and ambulatory care for low income children, with Medicaid-enrolled children accounting for half or more of all patients treated. The proposed national DSH cap would leave virtually all children's hospitals and public hospitals with reimbursement which is less than their reasonable costs. Moreover, the national cap policy would in effect penalize a child in Texas because the state of Arkansas was "too generous" with its hospitals. This is simply absurd.

4. Donated Funds

The agreement appropriately would exempt from donated funds prohibitions donations made by providers for administrative costs associated with eligibility determinations. But such donations would inexplicably also be limited to a cap of no more than 10 percent of state Medicaid administrative costs, regardless of the

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[2] Local governments may, under the agreement, use legitimate provider taxes to meet their local match requirements or arrange for intergovernmental transfers. However, the agreement appears to limit states' capacity to claim FFP for provider taxes to a 22 percent overall cap on non-federal expenditures No separate ceiling is established for governmental transfers derived from local provider specific taxes. In many states, therefore, this source of funds will be lost to localities..

actual cost of states' Medicaid enrollment assistance programs. Moreover, the agreement, for reasons we do not understand, appears to prohibit donations made not only by but also on behalf of health providers, even if the entity or organization donating the funds is not itself a health provider. We see absolutely no reason why a state agency should not be able to accept, spend, and treat as matchable non-provider charitable contributions to help defray the cost of its programs.

Conclusion

The Department's rule will cause nearly unimaginable program dislocation for millions of poor women and children. The rules fundamentally threaten many publicly funded health service systems for women and children. Moreover, the rules are utterly gratuitous. States would be penalized under the donated funds provisions of these rules not because they fail to make expenditures but simply because their expenditures do not fall within certain arbitrary recognized classifications.

While the agreement may be a start, it contains many problems -- problems far too serious and fundamental to be resolved during the final days of this session of Congress. We therefore urge the Senate to join the House in enjoining the Administration from enforcing its rules (if the Administration will not suspend its rules itself) for a reasonable period, so that this crisis can be permanently resolved.

Statement of Senator William V. Roth, Jr.

Thank you Mr. Chairman, when Medicaid was first established, the Federal Government assured States willing to establish their own Medicaid programs that they would get at least a dollar for dollar match on their costs. However, recently, many states have resorted to funding schemes which result in obtaining straight Federal dollars for portions of their Medicaid plan.

Perhaps some of the fiscal arrangements devised by the states are not the scams that this Committee has heard so much about, but, my home state of Delaware never implemented any such arrangement. In addition, legislation now being considered by the House would only bail out states who already have some scheme in place—this means that the taxpayers in states like Delaware will have to be further subsidizing the Medicaid programs in other states. Of course, Delaware could expand services to low income women, or seniors, or other areas, if a really good fiscal scam had been rigged. Instead, tough decisions were made, and the State is carrying its burden fairly.

Under current conditions, the cost of Medicaid is skyrocketing. The original intent for the Federal—State matching rate played a key role in keeping states fiscally responsible but many of these scams have eliminated that responsibility. While the regulations issued by the Department of Health and Human Services are not perfect, the States' use of these financing scams, in my view, go beyond the bounds of the original mission of the Medicaid program. I am aware of the fiscal constraints facing many States, but in some cases, this manipulation of Federal assistance appears to be abusive and almost fraudulent. I am particularly concerned that if these financial schemes are not regulated, then an unfair burden will be increased on States that never put one of these schemes in place.

Prepared Statement of Lucy Shaw

Mr. Chairman, members of the Committee, I am Lucy Shaw, President and Chief Executive Officer of the Regional Medical Center at Memphis, otherwise known as The Med. I am pleased to testify this morning on behalf of the National Association of Public Hospitals (NAPH), whose members include over 100 metropolitan area safety net hospitals. In particular, I am pleased to have this opportunity to describe for you the potentially devastating impact on The Med and other similar hospitals of HCFA's October 31 Medicaid financing regulations. I am accompanied this morning by Larry Gage, President of NAPH. Mr. Gage does not have a separate prepared statement, but he is available to answer any questions you may have about the impact on safety net hospitals nationally.

In summary, Mr. Chairman, the new HCFA rules will eliminate federal matching payments for provider donations, greatly restrict federal matching for services funded in part through provider-specific taxes, and possibly even reduce or eliminate the ability of local governmental entities to participate in funding the Medicaid program. In Tennessee and many other states, because of the increased demand for services by indigent patients and the weakness of the economy, these sources of funding have become an essential part of the Medicaid program.

It is no exaggeration to say that if these rules are allowed to go into effect on January 1, and local funding options are no longer available in Tennessee, it will mean disaster for Medicaid recipients and the hospitals that serve them.

The continued ability of safety net hospitals like The Med to keep our doors open to all persons, regardless of ability to pay, will be imperiled. Our trauma center, high risk obstetrics program, burn center and neonatal intensive care unit, all of which serve the entire mid-South, will be immediately threatened. Our ability to serve as family doctor for the poor and uninsured will also be in jeopardy. Although we will do our best to avoid it, if these regulations go into effect, many low income women, children and other Medicaid and uninsured patients will lose eligibility, lose access, lose the opportunity to improve their health status—and in some cases, possibly even lose their lives.

For these reasons, NAPH strongly urges this Committee to take immediate action to prevent HCFA from implementing these new rules, by adopting an extension of the current moratorium, as set forth in H.R. 3595 and S. 1886. Congress must impose this additional moratorium in order to allow the development of such important Medicaid policy in a more careful manner.

In the remainder of my prepared testimony today, I will discuss each of the issues raised above in greater detail. First, I will discuss the impact of these regulations nationally. Second, I will describe the Medicaid and indigent care services provided by The Med and discuss the Tennessee provider tax program. Third, I will tell the Committee why NAPH believes these regulations are clearly illegal. Fourth, I will provide the Committee with some specific observations on the proposed OMB/NGA staff "compromise."

PROVIDER TAX AND VOLUNTARY DONATION PROGRAMS ARE NOT "SCAMS"

It has been often suggested by the Administration that voluntary donation and provider tax programs are "scams" and "schemes" designed to use Federal Medicaid matching dollars for illegal purposes. This is simply not true. In most states, the use of local sources to augment the state's share of Medicaid spending has resulted in the essential, and often federally-mandated, continuation and expansion of Medicaid eligibility and services. It has also resulted in improved access and modest new initiatives for other uninsured indigent patients.

While isolated instances of abuses may exist, and should clearly be dealt with, the solution is not to outlaw the good programs along with the bad ones. A recent survey of 22 NAPH member hospitals in 13 states with donation or tax programs revealed that in no case *were funds being used for purposes other than Medicaid and indigent care*. Moreover, the survey revealed that in no case did Medicaid payments to providers even begin to meet the full needs and costs of serving Medicaid and other indigent patients. In fact, net losses at these hospitals from serving Medicaid and other indigent patients ranged from $2 million to $143 million, even after all Medicaid payments (including disproportionate share adjustments) and direct local subsidies were taken into account. Over half of these hospitals still experience losses in excess of $40 million. A table summarizing these results will be submitted for the record.

IMPACT ON THE MED AND TENNESSEE

In the case of The Med, our involvement in the Tennessee provider tax program meant that total Medicaid payments, including disproportionate share payments, will actually exceeded Medicaid costs by only $7 million in FY 1991. This modest additional resource from the provider tax program must be compared with The Med's $92 million in total uncompensated care for that year. It may be helpful to tell you a little more about The Med and the Tennessee program.

The Regional Medical Center at Memphis is a 620 bed tertiary teaching hospital. We experience over 22,000 admissions and over 200,000 outpatient and emergency room visits each year. While approximately 30% of our patients are Medicaid eligible, over 40% of our patients are uninsured. Just 18% have some form of private insurance and only 13% are covered by Medicare.

As a result of this patient mix, our bad debt and charity care costs are high and extremely burdensome at The Med, increasing from about $72 million dollars in

1988 to $92 million dollars in 1991. While we have received an annual local operating subsidy of $26.8 million dollars, that does not approach the cost of charity, much less bad debt and contractual write-offs. We have had no cash reserves, no investment income, and nowhere to turn if red ink bleeds onto our balance sheets. Our choice is to cut services to those who depend on us. Such services include the only burn unit; the only Perinatal outreach program and Level IV high risk obstetrics center; the only psychiatric emergency room; the only comprehensive prenatal substance abuse program; the only adult sickle cell treatment center; and the only Level I Trauma Center serving our areas residents and visitors. But for our Medicaid disproportionate share adjustments ("MDSA"), these services would evaporate, impacting both insured and uninsured.

Congress established the Medicaid program 26 years ago to take care of poor people, but a large group of non-Medicaid eligible, uninsured people remained and grew. Congress recognized that "Safety Net" hospitals like ours were filling the acute care needs of those uninsured, and set up MDSA to help us fund their care. Tennessee's MDSA continues as a model for strengthening the hospital Safety Net. Without it, THE MED would have buckled under the weight of its charity care expense.

Tennessee's experience is illustrative. Tennessee is a relatively poor state whose Federal Medicaid Percentage does not fully take into account the extent of the state's need or its difficulties in financing the state's share of Medicaid costs. See General Accounting Office, *Medicaid: Improving Funds Distribution,* HRD–91–66FS (May 1991). Tennessee has nonetheless implemented major Medicaid improvements, especially for poor children, in recent years. Concerned regarding its infant mortality rate, the state has met and exceeded Congressionally managed improvements in coverage for pregnant women and infants.

These changes, as well as accelerated implementation of the Qualified Medicare Beneficiary program, improved support for disproportionate share hospitals and other reforms, were first made possible with provider donations, and more recently with mandatory assessments on hospitals and nursing homes.

In 1990, the State of Tennessee imposed a provider tax on its most significant providers of care to the indigent. Let me say that this was not the kind of tax that safety net hospitals might have preferred. Nonetheless, it was the only one that could realistically be enacted in the time frame available. The State Medicaid program was facing a crisis. Without increased revenues, the program would have collapsed. A broad based tax was simply not politically possible. Given all of these circumstances, Tennessee's safety net providers agreed to be taxed to ensure the survival of Tennessee's Medicaid program.

Tennessee's provider tax structure began as part of an innovative approach to raising money to keep up with rising costs of meeting the health care needs of low income Tennesseans, including those who are uninsured as well as the Medicaid eligible. Beginning in 1987, Tennessee aggressively implemented improvements in eligibility in a Medicaid program which had been riddled by budget cuts in 1983. The annual 14 day limit on inpatient hospitalization was increased to 20 days in 1987, then made unlimited in 1989. Eligibility expansions for pregnant women, infants and children were made, exceeding Congress' mandates. Now, pregnant women and infants are covered up to 185% of the federal poverty level. Significantly, Tennessee's high infant mortality rate dropped from 11.7 per 1,000 live births to 10.8 per 1,000 live births between 1987 and 1989.

For all categories, the number of people eligible for Medicaid increased from just over 500,000 to almost 900,000, at a time when the state's economy simply could not have generated sufficient revenues from any other source to finance such expansion. During this same period, the total units of service provided to Medicaid recipients increased from 23 million to over 38 million, while at the same time the cost of each unit increased from $37 to nearly $45.

For these reasons, a substantial portion of the new Medicaid revenues generated through The Med's tax payments are not returned to The Med in increased payments, but rather are used by the State for other important Medicaid expenditures. In fact, The Med's anticipated tax payments in the current fiscal year will generate over $57 million in new resources over and above Medicaid payments to THE MED, which the state will use to fund increased eligibility and the increased cost of services generally. Net payment adjustments to The Med this year are expected to increase by just $8 million. In all, in FY 1992, the Tennessee program used a total of $354,396,000 in local provider taxes paid by hospitals and nursing homes, to help finance a $2.5 billion Medicaid program.

Congress had the example of Tennessee in mind when it enacted OBRA '90. There was a clear intent, expressed in Clause (b)(1) of Section 4701, to affirm and perma-

nently protect the states' use of provider assessments to meet their Medicaid financing responsibilities.

Tennessee also continued to rely on donations. A permanent federal policy with regard to the matching of such revenues remained to be established. Congress was concerned that if there were a change in the federal treatment of donated funds, states such as Tennessee should be afforded an opportunity to adjust their revenue policies to avoid budget and/or programmatic dislocations. With that end in mind, Congress last year sought to ensure that states using donations would have at least until December 31, 1991 to make other revenue provisions.

In light of OBRA'90, Tennessee revised and expanded its hospital and nursing home tax programs and ended its reliance on donations. Although provider revenues that were once voluntary are now mandatory, and are substantially increased, the source of those revenues, and the uses to which they are put, are little changed in their basic character from the state policies previously approved by the HHS Department Appeals Board.

Since the implementation of the original provider revenue-financed Medicaid improvements, Tennessee has seen as significant drop in its infant mortality rate, from 11.7 per 1,000 live births to 10.8 per 1,000 live births between 1987 and 1989. The State's strong continued commitment to improving health outcomes among the poor was reflected in its expansion, in the current fiscal year that began July 1, 1991, of Medicaid coverage to reach pregnant women and infants with incomes of up to 185% of the poverty level. The State's election of this coverage option authorized by OBRA '89 was particularly noteworthy since it occurred in the midst of a state budget crisis in which almost every other section of state government activity suffered substantial budget reductions. Tennessee, consistent with federal statutes, also broadened and enhanced its Disproportionate Share hospital program.

Now Tennessee, having pursued important state and national health objectives while consistently tailoring the financing of its Medicaid program to the requirements of federal law, faces catastrophic dislocations as a result of the Secretary's interim final regulations. The effect of the September 12, 1991 regulations will be to slash $550 million from Tennessee's fiscal year 1991 Medicaid budget, halfway through the fiscal year. This represents a 24% reduction in the entire program budget. Annualized, this will cut approximately $1.1 billion from the Medicaid budget, or approximately 50% of expenditures. Inevitably, state officials would be forced to impose massive reduction in eligibility, services and payments. The tragic consequences of such reductions would include substantial human suffering and loss of life among the approximately 800,000 Tennesseans dependent upon the state's Medicaid program, as well as among the nearly one million uninsured Tennesseans who must turn to Disproportionate Share hospitals' as their providers of last resort. Those same hospitals, many of which are in underserved rural areas, provide health services to the general public that are not available elsewhere in their communities. The magnitude of the threatened Medicaid cuts poses such as peril to their financial stability that it jeopardizes the state's health care infrastructure.

THE PROPOSED REGULATIONS ARE CLEARLY ILLEGAL UNDER CURRENT LAW

As the projected impact on Tennessee and other states clearly indicates, HCFA's interim final rules will mean the denial of necessary health care to low income mothers, infants, trauma victims, patients with AIDS and those suffering from drug abuse. But not only do the rules represent bad policy, they are also illegal under current Medicaid law.

Last year, Congress spoke on the issue of federal matching of provider taxes. In the Omnibus Budget Reconciliation Act of 1990, Congress decided that HCFA was to continue to match provider taxes, whether or not these taxes are of general applicability. The only exception to this proscription provided that the Secretary could deny federal matching payments where a provider is "reimbursed" for the cost of a tax. As Congressman Waxman, Chairman of the Health Subcommittee, House Energy and Commerce Committee, has written, this exception was intended to insure that hospitals did not include the cost of a provider tax on a Medicaid cost report.

HCFA has blatantly ignored Congressional intent. It has instead usurped Congress' role and legislated by regulation. The interim final rule will allow HCFA to deny federal matching payments wherever it finds "linkage" between provider taxes and provider reimbursement. It has allowed itself unlimited discretion to find such linkage. Essentially, HCFA has permitted itself the freedom to match the taxes it likes and deny matching payments for those it doesn't like.

In promulgating this rule, HCFA has also ignored over twenty-five years of Medicaid history. Local participation in Medicaid funding, especially by governmental entities, has been an integral part of the Medicaid program since its very inception.

Use of local funding sources for up to 60% of the non-federal share is clearly authorized by Section 1902(a)2 of the Medicaid statute.

The ability of states to use local funding sources was not an accident, but was in fact a conscious decision of the Congress to adopt the position of the Senate in this area. Legislation creating the Medicaid program as originally introduced in the House of Representatives required States to provide 100 percent of non-federal expenditures. The House bill was amended in the Senate to allow local sources to fund a portion of the non-federal share. 111 Cong. Rec. 15791 (July 7, 1965). The Conference Report explaining the Senate amendment states:

> "The House bill . . . required . . . a State plan for medical assistance to provide that all of the non-federal funds under it shall be from State, rather than State and local sources. The Senate amendment provided as an alternative that, if a State, on an equalization or other basis, could assure that lack of adequate funds from local sources would not result in lowering the amount, duration, scope, or quality of care and services available under the plan, local funds could continue to be utilized to meet the non-federal share of expenditures under the plan." H.R. Cong. Rep. No. 682, 89th Cong. 1st Sess. 50 (1965).

In fact, local governments have shared responsibility with states for funding Medicaid expenditures since the beginning of the Medicaid program, and federal matching payments have always been available for these local government funds. Since at least 1977 (and possibly earlier) local health care providers have also funded a portion of the non-federal share of Medicaid expenditures in many states. Federal matching payments have also been available for these local provider funds.

For these reasons, NAPH believes that it is clearly illegal for HCFA to attempt to eliminate local funding sources through regulation. As a result, a group of NAPH member hospitals, led by Atlanta's Grady Memorial Hospital, asked the federal courts last Thursday to declare these regulations illegal.

While NAPH is hopeful that the courts will overturn these illegal regulations, we agree that litigation is ultimately not the best way to address any policy decision of this magnitude, involving the future of the Medicaid program and the federal commitment to serving the poor. Congress is clearly the appropriate forum to address these vital questions of access, financing and care for the poor, and Congress should do so deliberately, with ample time to give a full and careful consideration to these highly complex issues. It is therefore imperative either that HCFA withdraw these regulations, or that Congress impose a moratorium on their implementation, so that such deliberations may proceed.

COMMENTS ON PROPOSED NGA STAFF "COMPROMISE"

Finally, we understand that there has been some discussion of a "compromise" being negotiated between OMB and certain staff members of the National Governor's Association. From what we can gather, this "compromise" goes far beyond the provisions of the new regulations, involving important and complex issues such as the adequacy of Medicaid payment rates generally, the relationship of Medicaid to Medicare, and disproportionate share hospital adjustments. We are gratified that the OMB "compromise" was rejected last week by a substantial majority of Governors. However, the very fact that Administration "negotiations" on such vital matters could occur behind closed doors, without the involvement of the Congress or other affected parties, such as providers, recipients, or State Medicaid directors, sets a dangerous precedent.

NAPH would be pleased to participate in a deliberate, reasoned debate of the many important questions raised by these regulations, as well as other issues, such as the adequacy of current Medicaid hospital payment methodologies and the most appropriate means of financing health care for all uninsured Americans. What we must not do, however, is act precipitously, with artificial deadlines such as the desire of the Congress to recess by Thanksgiving. Now that this debate has been expanded to include major, historic changes in the heart of the Medicaid program, it is imperative that the issues be addressed carefully and thoughtfully.

In conclusion, the Congress must continue to demand that HCFA withdraw these regulations, or extend the current moratorium to prevent HCFA from enforcing them, while we weigh all of the complex issues in a more careful and deliberate manner next year.

Again, I appreciate this opportunity to testify, and I would be happy to answer any questions you may have at this time.

CHANGES IN MEDICAID BY GROWTH FACTOR

Fiscal Year	Eligibles	Units of Service	Cost per Unit
FY 86-87	507,934	23,260,113	$36.78
FY 87-88	540,404	25,899,569	$39.21
FY 88-89	611,993	30,183,896	$38.51
FY 89-90	693,714	33,801,400	$39.88
FY 90-91	781,011	38,305,023	$44.79
FY 91-92	879,279	42,901,626	$53.40
*FY 91-92**	*879,279*	*42,901,626*	*$47.47*

* without enhanced MDSA

FY 91-92 expenditures are projected

Table 1: Information Regarding Medicaid Revenues for a Select Group of Hospitals

Hospital		Fiscal Year	Medicaid Costs For Patient Care		Medicaid Revenues Rec'd For Patient Care (Less DSH Payments)		Medicaid Net Income/Loss (Pt. Costs – Pt. Revenues)		Medicaid DSH Payment	Total Medicaid Net Income + DSH Payment	Total Uncompensated Patient Care	Local Subsidies	Total Net Income
			Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient					
Denver General	Transfer	1/1/90–12/31/90	18,472,000	9,618,000	18,200,000	5,800,000	(272,000)	(3,818,000)	600,000	(3,490,000)	89,400,000	32,100,000	(60,790,000)
Harris Cty. Hosp. Dist.	Transfer	4/1/90 – 3/31/91	44,737,670	11,305,887	31,546,522	8,933,815	(13,191,148)	(2,372,072)	2,574,997	(12,988,223)	263,147,331	176,253,044	(99,882,510)
Parkland Memorial	Transfer	10/1/89 – 9/30/90	21,908,853	2,379,930	23,052,723	2,302,881	1,143,870	(77,049)	3,200,000	4,266,821	224,968,660	128,709,000	(91,992,839)
Regional Med. Ctr. @ Memphis	Tax	7/1/90 – 6/30/91	43,921,377	5,984,911	27,942,698	7,985,550	(15,978,681)	2,000,639	18,187,426	4,209,384	92,600,000	26,800,000	(61,590,616)
Grady Memorial	Donation	1/30/90 – 12/31/90	34,931,248	15,949,757	32,491,306	15,298,509	(2,439,942)	(651,248)	1,009,822	(2,081,368)	147,753,714	99,464,252	(50,370,830)
Wishard Memorial	Tax (pending)	1/1/90 – 12/31/90	25,419,198	7,404,328	24,364,545	6,820,803	(1,054,651)	(583,525)	5,102,336	3,464,160	46,441,747	33,010,048	(9,967,539)
Univ. of North Carolina	Donation	7/1/90–6/30/91	49,605,719	3,478,779	39,586,399	3,268,194	(10,019,320)	(210,585)	4,971,708	(5,258,197)	39,520,377	0	(44,778,574)
Merrithew Memorial	Transfer (pending)	7/1/90 – 6/30/91	14,765,143	11,164,968	12,219,618	7,762,784	(2,545,525)	(3,402,184)	1,300,000	(4,647,709)	24,564,342	25,558,439	(3,653,612)
Highland Hospital	Transfer (pending)	7/1/90 – 6/30/91	42,479,705	9,312,326	36,219,541	6,870,260	(6,260,164)	(2,442,066)	165,303	(8,536,927)	39,213,550	31,135,154	(16,615,323)
Jackson Memorial	Tax & Transfer	10/1/90 – 9/30/91	115,785,890	19,375,898	102,246,146	18,030,568	(13,539,744)	(1,345,330)	24,472,000	9,586,926	217,736,343	94,879,992	(113,269,425)
LAC+USC Med. Center	Transfer (pending)	1/7/90 – 6/30/91	220,720,877	27,235,387	215,883,768	12,983,177	(4,837,109)	(14,252,210)	1,956,000	(17,133,319)	193,621,783	67,521,830	(143,233,272)
LAC/ Harbor/UCLA Med. Ctr.	Transfer (pending)	1/7/90 – 6/30/91	95,339,958	20,887,011	84,503,057	11,180,503	(10,836,901)	(9,706,508)	998,000	(19,545,409)	71,290,956	22,797,986	(68,038,379)
LAC/Rancho Los Amigos	Transfer (pending)	1/7/90 – 6/30/91	80,882,089	10,606,120	72,180,589	4,085,497	(8,701,500)	(6,520,623)	1,041,000	(14,181,123)	28,564,421	14,476,994	(28,268,550)
LAC/MLK/Drew Med. Ctr.	Transfer (pending)	1/7/90 – 6/30/91	79,402,282	19,025,704	67,905,565	6,648,048	(11,496,717)	(12,377,656)	632,417	(23,241,956)	65,481,423	59,487,115	(29,236,264)
LAC/Olive View Med. Ctr.	Transfer (pending)	1/7/90 – 6/30/91	52,166,194	26,814,254	57,927,244	15,690,143	5,761,050	(11,124,111)	978,192	(4,384,869)	60,371,505	15,243,562	(49,512,812)
LAC/High Desert Hospital	Transfer (pending)	1/7/90 – 6/30/91	11,988,428	5,081,070	9,128,604	3,613,459	(2,859,824)	(1,467,611)	18,974	(4,308,461)	10,676,071	7,151,168	(7,833,364)
Pontiac General Hospital		1/1/90 – 12/31/90	10,835,271	3,522,384	11,462,180	2,396,222	626,909	(1,126,162)	0	(499,253)	3,992,465	0	(4,491,718)
St. Paul–Ramsey Med. Ctr.+		1/1/90 – 12/31/90	11,239,637	3,027,729	9,357,160	1,544,142	(1,882,477)	(1,483,587)	525,830	(2,840,234)	8,018,221	2,599,419	(8,259,036)
Oklahoma Medical Center		7/1/90 – 6/30/91	54,262,000	22,368,000	48,819,000	10,651,000	(5,443,000)	(11,717,000)	17,478,000	318,000	41,613,000	39,309,000	(1,986,000)
UMDNJ – University Hospital		1/1/91 – 12/31/91	37,131,931	15,473,376	37,737,465	10,012,243	605,534	(5,461,133)	2,161,302	(2,694,297)	71,000,000	62,000,000	(11,694,297)
Harborview Med. Ctr.*	Transfer (pending)	7/1/91 – 6/30/92	72,298,000		45,144,000		(27,154,000)	0	30,483,000	3,329,000	48,742,000	8,877,000	(36,536,000)

* The numbers for Harborview are combined to include both inpatient and outpatient services.

+St. Paul – Ramsey Med. Ctr. could only provide Medicaid charges not Medicaid costs.

Source: National Association of Public Hospitals

Prepared Statement of Gail R. Wilensky

Mr. Chairman and Members of the Subcommittee. I am pleased to be here this morning to discuss with you the Health Care Financing Administration's recent actions regarding State donation and provider tax programs.

INTRODUCTION

The Medicaid program plays an important role in meeting the health needs of our nation's most vulnerable citizens. This program must remain strong and stable to ensure that the poor receive essential health services.

State donation and tax programs present a complex issue, but it is clear that they have the potential to undermine a basic premise of the Medicaid program—that funding be shared through a Federal match of State monies. In a matching program, those responsible for expenditure decisions and the direct fiscal management of the program must have a reasonable stake in program costs. This shared responsibility works to shape their decisionmaking to contain costs. The requirement for a State share of payment has always acted as a restraint on the otherwise open-ended Medicaid program.

Without a limit on evolving State donation and tax programs, we will move quickly toward a system of *fourth party payment* where the Federal government, not the patient, the provider, or the manager of the program is at risk for the cost of services. State provider tax and donations programs threaten to alter fundamentally the intended funding relationship between Federal and State governments.

Federal Medicaid obligations increased 17 percent from 1989 to 1990, and a 31 percent increase is projected for 1991. Provider donations and tax programs are partly responsible, and represent a potentially huge Federal budgetary increase.

The Department's Inspector General reported on the exponential growth of these programs. In 1986, only West Virginia was using donations as the State's share of Medicaid funding. By the middle of 1991, 38 States were using donation and tax programs. Today, I understand all but six States have a plan to use these programs.

Estimates of Federal funds being requested by States to match donations and taxes illustrate the rapid growth of these programs during the last year. In October 1990, the Inspector General reported that $497 million in matching funds were requested by 9 States. By May of 1991, 18 States had requested $2.5 billion—five times the amount requested just over half a year earlier. By July 1991, 30 States had requested $3.8 billion in Federal matching funds.

Unless restrained, the growth in Federal matching funds for state donations and taxes is not expected to abate. HCFA currently estimates States will request at least $5.5 billion in Federal matching funds for donation and tax programs in FY 1992.

We believe that some States are using these "free" Federal funds to increase services, expand access, and make other positive changes. But nothing in the current situation even allows us to ensure that "free" Federal funds are used in this manner.

In fact, the Inspector General reported "these programs are generally not used to increase services to Medicaid recipients or improve the quality of care. More often, they are 'carefully crafted' finance techniques that allow States to reduce their share of Medicaid costs and force the Federal government to pay more."

In any case, States can use Federal funds generated through donation and tax programs for any purpose they want.

PROGRAM BACKGROUND

The proportion of Federal financial participation in Medicaid spending is determined by a formula based on per capita income levels within a State. The Federal share can range from 50 percent to 83 percent, and States must first produce their share of payments to providers before receiving Federal funds. Over the last 5 and a half years, over 50 Congressional mandates, by our count, have required States to expand their Medicaid coverage and services well beyond the original scope of the program. For this and other reasons, Medicaid expenditures now represent over 16 percent of most State budgets. According to the National Association of State Budget Officers, Medicaid is the second fastest growing item in State budgets.

Governors and State Medicaid Directors, searching for ways to fund their programs, have turned to elaborate financing methods to increase the amount of dollars they can obtain from the Federal government.

Some States use these financing mechanisms to decrease their overall, true State spending on Medicaid, without decreasing eligibility, services or payments to providers. Other States use donations and taxes to expand Medicaid or increase their payment to providers at little or no cost to the State.

We recognize that some States have put the additional funding to good use. But, we are concerned that 100 percent Federal funding distances State program managers from concerns about program costs, and exposes the Federal government to potentially huge fiscal liabilities.

DONATIONS AND TAXES: HOW THEY WORK

Donation and tax programs vary from State to State but they alter the Medicaid matching rate in basically the same way. These programs typically work as follows:

- States "borrow" money from providers (usually hospitals) through donations or tax programs;
- This money is used as the State share of Medicaid and is matched, at least dollar for dollar, by Federal funds. One state now receives 4 Federal dollars for every single dollar it contributes as its share.
- States frequently increase Medicaid payments to reimburse providers for the donations or taxes they paid.
- The State then uses the Federal matching funds to pay providers for Medicaid services. In many States, providers are guaranteed to get back at least as much as they donated or paid in provider-specific taxes through "hold harmless" mechanisms.

As an illustrative example, suppose hospitals were being paid $100 million under Medicaid. Assuming that the match rate is 50 percent, the State and the Federal government each would pay $50 million. The State then both: implements a donation or tax program and receives $100 million from hospitals; and increases the payment to the hospitals to $200 million. The State then receives an additional $100 million in Federal matching funds.

Under this scenario, hospitals are actually getting the same net payment of $100 million after deducting the cost of the donation or tax but now this $100 million is 100 percent Federally funded.

Before the financing scheme the State paid 50 percent of the provider payment, or $50 million. Now, the Federal government pays the entire $100 million; *the State pays nothing*. Provider payments and Medicaid services remain the same. In this State, then, the Federal matching rate has gone from a nominal 50 percent to an effective 100 percent.

Overall, the Federal government ends up paying a higher effective Medicaid matching rate.

MEDICAID REFORM

If these arrangements are allowed to continue unabated, a significant shift in the intended, shared funding relationship of Federal and State governments will occur. In addition, States that choose not to engage in donation and tax programs are disadvantaged relative to other States. Their citizens feel the negative, national effects—for example, higher deficits—that increased Federal outlays associated with donation and tax programs cause, without the benefit of those dollars flowing to their State.

This fundamental change in the Medicaid program should not be permitted to occur without full and open policy discussions on all issues, including financing the cost of any changes. The implications of major changes in Medicaid should be considered within the larger public debate on health care reform issues.

As Medicaid currently exists, States are accountable for the partial funding and proper management of their programs. It is in this spirit that HCFA will continue to monitor and review the methods States use to operate and fund medical assistance for their eligible populations.

HISTORY OF THE PROPOSED RULE

In 1985, HCFA allowed States to accept private or public donations as a State's share of financial participation for the entire program. previously donations had been acceptable only for training programs. Tax policy, described in instructions issued to State Medicaid agencies, allowed Federal matching funds only for taxes that apply to all types of businesses in a State.

In 1986, several States began using donations as a significant substitute for State funding. HCFA attempted to restrict these programs, but, ultimately decided that a new regulation was needed.

In 1988, Congress imposed a one year moratorium on any regulatory change. This was continued in 1989.

In February 1990, HCFA published a proposed regulation that addressed both donation and tax policies. HCFA proposed, before determining actual expenditures

qualifying for matching, to subtract from nominal State expenditures the revenue to a State from either a donation from a provider or a provider-specific tax.

In November 1990, the enactment of OBRA 90 continued the moratorium on issuing a final donations regulation until January 1, 1992. OBRA 90 also prohibits matching funds when States reimburse hospitals, nursing facilities, or ICFs/MR for costs "attributable to" taxes imposed solely on these facilities. provider-specific taxes not linked to Medicaid institutional payments will still be eligible for full Federal financial participation.

On September 12, 1991, HCFA published an Interim Final Rule (IFR) interpreting the OBRA 90 tax provisions and prohibiting the use of provider donations. The public was given 60 days to comment on this rule. To eliminate the confusion that emerged during the comment period, we issued a clarification on October 29, 1991.

This clarification was intended to correct several deficiencies in the September 12 version of the regulation. Most importantly, the issue of intergovernmental transfers was clarified. The September 12 rule could be read broadly to eliminate intergovernmental transfers, including long-standing State practices. HCFA did not eliminate the use of all intergovernmental transfers. Our clarification explicitly states that legitimate public funds transferred between different levels of local government would continue to be allowed under current law.

One example of a legitimate intergovernmental transfer would be where States require county property taxes to be contributed to the Medicaid program. These funds would be matched with Federal dollars so long as the taxes were not provider-specific or not linked to Medicaid payments. Another example would be where a county Maternal and Child Health Agency has been contributing money to the State's Medicaid program or certifying that services were provided to Medicaid patients. Again, these resources would continue to be matched with Federal dollars as a legitimate contribution to the program.

In other words, county-generated taxes and donations will be viewed in the same manner as state-generated taxes and donations for the purpose of Federal matching funds. For Federal matching purposes, counties and local governments will be bound by the same rules for generating this income as States.

The October clarification also clearly defines the provider-specific tax payments not allowed for Federal matching. The total amount of taxes to be withheld from matching is the lesser of a provider's entire provider-specific tax payment or the portion of Medicaid payments to the provider that can be attributed to its tax payment. We believe this interpretation is fully consistent with Congressional intent and reflects the best reading of the OBRA 90 language.

We recognized that many States would need to convene their legislatures to revise their Medicaid funding programs or otherwise address the effect of the interim final rule on their budgets. The October rule provides a delayed effective date of July 1, 1992, for States which: (1) submit an application by January 2, 1992, describing the changes they will make to their donation and tax programs to achieve compliance with the rule; and (2) enter into an agreement with HCFA to implement such changes no later than July 1, 1992. If the revised donation and tax programs are put into effect by that date, HCFA will not disallow costs related to the previous donation and tax programs for the period between January 1, 1992 and July 1, 1992.

FURTHER DISCUSSION

We continue to believe our rules are consistent with the OBRA 90 statute, but we recognize that there are strongly held views to the contrary.

With most States involved in donations and tax programs to finance Medicaid, we are aware that our rulemaking is controversial, even though we have provided a transitional period for States to meet the rule's terms. Since publication of the October 31 clarification, States have continued to be extremely vocal in their concern about the effect of these regulations on their budgets.

Therefore, in light of:

- the potentially disruptive nature of the rule;
- the difficulty States face in trying to balance budgets with out-of-control Medicaid costs and soft economies;
- the controversy over our interpretation of the OBRA 90 statutory language; and
- the complicated technical, administrative, and interpretive issues involved in implementing the rule

We believe a legislative change is preferable to the rule taking effect. We are working with the National Governors' Association as part of our efforts to develop such legislative options.

As you know, on November 7 the House Energy and Commerce Committee passed amendments to extend and modify the moratorium, through September 30, 1992, on the issuance of any regulation changing the treatment of voluntary contributions or provider-specific taxes.

If this legislation is enacted, we will return to a situation that allows existing donation programs to continue and gives States unrestrained ability to obtain Federal matching funds using refundable, provider-specific tax schemes. The short-term Federal exposure to increased Medicaid spending will be virtually unlimited. The transition from this extended moratorium could potentially be much more difficult for the States than if steps are taken now to revise our approach to donations and taxes.

CONCLUSION

Without regulations or a legislative change, the financing burden on States will shift to the Federal government and seriously jeopardize the current Medicaid program. Full Federal funding will mean that States will no longer feel pressure to control costs and manage the program efficiently.

We believe a legislative solution is needed to set clear boundaries for States and give HCFA the administrative flexibility to address the difficulties this issue has posed.

States *are* accountable for the appropriate management and financing of their programs, and the Federal government is responsible for holding them accountable. It is my intention, then, to safeguard the Federal resources currently available, while maintaining quality medical care for all our Nation's vulnerable citizens.

We, at HCFA, will continue to discuss with States their unique problems and to explore acceptable funding arrangements. Likewise, I am looking forward to hearing the Committee's views and working with you to bring this issue to resolution.

RESPONSES OF GAIL WILENSKY TO QUESTIONS SUBMITTED BY SENATOR MITCHELL

Question No. 1. As you know, the State of Maine has developed a provider-specific tax plan. Maine was given technical assistance in the development of its plan by staff at Region I HCFA in Boston. Why was HCFA staff willing to assist with the development of Maine's plan when they must have been aware of the pending regulations?

Answer. Staff at HCFA Region I in Boston provided the State of Maine with technical assistance necessary to the development of a provider-specific tax plan only insofar as it was appropriate to do so under existing statutory authority. However, Region I did not encourage developments beyond that point.

Question No. 2. Maine, like many other states, is in serious fiscal crisis. If the provider-specific plan cannot go forward health care services to our poorest citizens will be jeopardized. If States' provider-specific tax plans are prohibited, how do you expect states to raise the revenues needed to maintain services to the poor?

Answer. Subsequent to the passage of H.R. 3595 as amended by Senate and House conferees, provider-specific taxes are allowed to be implemented by states up to 25 percent of a State's Medicaid expenditure.

Question No. 3. One of the key issues being negotiated between the Administration and the NGA is the question of "linkage"—of assuring hospitals or other providers that the amount taxed will be returned. HCFA is opposed to "direct linkage" and uses the State of Florida as an example of an acceptable arrangement with reimbursement to its hospitals.

Maine is a rural state with only 42 hospitals—half of which are reimbursed at the rural rate. Many of our rural hospitals have a high percentage of Medicare patients AND a high utilization rate. I am concerned about the fiscal viability of these hospitals if they are unable to recapture the amount of revenue lost in the provider-specific tax proposal.

Have you taken this type of scenario into consideration during your discussions with the Governors? If not, I urge you to do so.

Answer. States are allowed extensive flexibility under current law, as recently passed, to categorize hospitals as disproportionate share while HCFA is prohibited from issuing regulations on this issue.

RESPONSES OF GAIL WILENSKY TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Question No. 1. There has been some discussion, I understand about a *2-way moratorium.* Current State programs would be grandfathered into a time-limited moratorium and no new State programs could be enacted during this period of time.

West Virginia's provider tax program was enacted into law on November 4 of this year. Would you support a grandfather provision that would include State programs that were enacted by November 15, 1991? Why or why not—taking into account that HCFA did not issue its final clarification until October 31, 1991 and that the legislation enacted in West Virginia was the result of an intense 6 months of debate and discussion and not thrown together when it looked like special treatment might be available to established programs?

Answer. The Conference substitute for H.R. 3595 allows Federal matching to continue, until at least October 1, 1992, for provider tax programs enacted on or before November 22, 1991. Therefore, West Virginia's provider tax enacted on November 4, 1991 will qualify for Federal matching funds during the transition period.

Question No. 2. You have said that states ought to come in and sit down and talk about fundamental reforms of the Medicaid program rather than changing the traditional financing relationship of the Medicaid program through the backdoor via financing arrangements that rely on voluntary donations or provider taxes. What types of Medicaid reforms is HCFA interested in discussing?

Answer. The types of reform HCFA was interested in discussing regarding Medicaid reforms related to the issue of backdoor financing arrangements that rely on voluntary donations or provider taxes. The States, through the National Governors' Association, did in fact discuss these issues and related reform options with HCFA. These HCFA–NGA discussions formed the basis of the Medicaid legislation recently passed by both the Senate and the House.

[Attached is Table 4 from the "OMB Final Sequestration Report to the President and Congress for Fiscal Year 1992," dated January 13, 1992, which shows, at Budget Number 32, OMB's scoring for the "Medicaid Voluntary Contributions and Provider Tax Amendments of 1991," (P.L. 102–234).]

Table 4. **PAY-AS-YOU-GO-LEGISLATION ENACTED AS OF JANUARY 3, 1992**
(In millions of dollars)

Report Number		Change in the baseline deficit					
		1991	1992	1993	1994	1996	1991–96
1	Tax Relief for Desert Storm Participants (H.R. 4; P.L. 102–2):						
	OMB estimate [1]	1	5	0	0	0	6
	CBO estimate [1]	1	5	0	0	0	6
2	Veterans Compensation Amendments (H.R. 3; P.L. 102–3):						
	OMB estimate	0	0	0	0	0	0
	CBO estimate	0	0	0	0	0	0
3	Agent Orange Act (H.R. 556; P.L. 102–4):						
	OMB estimate	0	0	0	0	0	0
	CBO estimate	0	0	0	0	0	0
4	Veterans Education and Employment Programs (H.R. 180; P.L. 102–16):						
	OMB estimate	*	*	*	*	*	2
	CBO estimate	2	2	2	2	1	9
5	Resolution Trust Corporation Funding Act (S.419; P.L. 102–18):						
	OMB estimate	4	0	0	0	0	4
	CBO estimate	0	0	0	0	0	0
6	Persian Gulf Conflict Supplemental Authorization and Personnel Benefits Act (S.725; P.L. 102–25):						
	OMB estimate	—	—	—	0	0	0
	CBO estimate	—	—	—	145	170	315
7	Higher Education Technical Amendments (H.R. 1285; P.L. 102–26):						
	OMB estimate	-6	-38	—	—	—	-44
	CBO estimate	3	-56	5	*	*	-48
8	Department of Veterans Affairs Health Care Personnel Act (H.R. 598; P.L. 102–40):						
	OMB estimate	*	*	—	—	—	1
	CBO estimate	*	*	—	—	—	1
9	Rehabilitation Act Amendments (H.R. 2127; P.L. 102–52):						
	OMB estimate	—	—	0	0	0	0
	CBO estimate	—	—	0	0	0	0
10	Veterans Housing Amendments (H.R. 232; P.L. 102–54):						
	OMB estimate	*	1	*	*	*	1
	CBO estimate	0	5	3	1	0	9

Table 4. PAY-AS-YOU-GO-LEGISLATION ENACTED AS OF JANUARY 3, 1992—Continued

(In millions of dollars)

Report Number		Change in the baseline deficit: 1991	1992	1993	1994	1995	1991–95
11	Veterans' Benefits Programs Improvement Act (H.R. 1047; P.L. 102–86):						
	OMB estimate	0	6	3	3	3	15
	CBO estimate	*	3	3	3	3	12
12	Intelligence Authorization Act (H.R. 1455; P.L. 102–88):						
	OMB estimate[2]	*	*	*	*	*	1
	CBO estimate[2]	*	*	*	*	*	1
13	Emergency Unemployment Compensation Act (H.R. 3201; P.L. 102–107):						
	OMB estimate	0	0	0	0	0	0
	CBO estimate	—	—	—	—	—	—
14	Armed Forces Immigration Adjustment Act (S. 296; P.L. 102–110):						
	OMB estimate	—	-*	*	0	0	0
	CBO estimate	—	0	0	0	0	0
15	Veterans' Educational Assistance Amendments of 1991 (S. 868; P.L. 102–127):						
	OMB estimate	—	—	2	2	2	7
	CBO estimate	—	*	*	*	10	10
16	Most-Favored-Nation Tariff Treatment for Mongolia (H.J.R. 281; P.L. 102–157):						
	OMB estimate	—	0	0	0	0	0
	CBO estimate	—	0	0	0	0	0
17	Most-Favored-Nation Tariff Treatment for Bulgaria (H.J.R. 282; P.L. 102–158):						
	OMB estimate	—	-1	-1	-2	0	-4
	CBO estimate	—	2	0	0	0	2
18	Veterans' Compensation Rate Amendments of 1991 (H.R. 1046; P.L. 102–152):						
	OMB estimate	—	0	0	0	0	0
	CBO estimate	—	0	0	0	0	0
19	Civil Rights Act of 1991 (S. 1745; P.L. 102–166):						
	OMB estimate	—	0	1	5	5	11
	CBO estimate	—	0	1	5	5	11
20	Emergency Unemployment Compensation Act of 1991 (H.R. 3575; P.L. 102–164) and Termination of Application of Title IV of the Trade Act to Czechoslovakia & Hungary (H.R. 1724; P.L. 102–182):						
	OMB estimate (two bills)[3]	—	-53	-421	-406	-427	-1307
	CBO estimate (two bills)[3]	—	1,747	-51	-48	-48	1,600
21	Intelligence Authorization Act, Fiscal Year 1992 (H.R. 2038; P.L. 102–183):						
	OMB estimate	—	-*	-*	-*	-*	-*
	CBO estimate	—	-*	-*	-*	-*	-*
22	National Defense Authorization Act, Fiscal Year 1992 (H.R. 2100; P.L. 102–190):						
	OMB estimate	—	-8	-21	-22	-23	-73
	CBO estimate	—	-7	-19	-19	-19	-64
23	Most-Favored-Nation Tariff Treatment for the Soviet Union (H.J.R. 346; P.L. 102–197):						
	OMB estimate	—	15	21	22	25	84
	CBO estimate	0	22	—	—	—	22
24	Patent & Trademark Office Authorization Act of 1991 (H.R. 3531; P.L. 102–204):						
	OMB estimate	—	0	0	0	0	0
	CBO estimate	0	0	0	0	0	0
25	James Madison Memorial Fellowship Foundation Amendment (H.R. 3932; P.L. 102–221):						
	OMB estimate	—	*	1	1	1	3
	CBO estimate	—	*	1	1	1	3
26	Health Education Assistance Loan Program Amendment (S. 2060; P.L. 102–222):						
	OMB estimate	—	0	0	0	0	0

Table 4. PAY-AS-YOU-GO-LEGISLATION ENACTED AS OF JANUARY 3, 1992—Continued

(In millions of dollars)

Report Number		Change in the baseline deficit					
		1991	1992	1993	1994	1995	1991-95
	CBO estimate	----	0	0	0	0	0
27	Tax Extension Act of 1991 (H.R. 3245; P.L. 102-227):						
	OMB estimate	—	-566	-244	-5	-514	-1,329
	CBO estimate	—	-405	46	308	-170	-223
28	Chatahoochee Forest Protection Act of 1991 (H.R. 3245; P.L. 102-217):						
	OMB estimate	—	0	0	0	0	0
	CBO estimate	----	0	0	0	0	0
29	San Carlos Indian Irrigation Project Divestiture Act (H.R. 1476; P.L. 102-231):						
	OMB estimate	—	10	2	2	2	15
	CBO estimate	----	-2	7	-1	-1	3
30	Miscellaneous and Technical Immigration and Naturalization Amendments of 1991 (H.R. 3049; P.L. 102-232):						
	OMB estimate	----	0	0	0	0	0
	CBO estimate	----	0	0	0	0	0
31	Resolution Trust Corporation Refinancing, Restructuring, and Improvement Act of 1991 (H.R. 3435; P.L. 102-233):						
	OMB estimate	----	35	37	10	10	92
	CBO estimate	----	25	37	42	41	145
32	Medicaid Voluntary Contributions and Provider-Specific Tax Amendments of 1991 (H.R. 3595; P.L. 102-234):						
	OMB estimate	—	0	0	0	0	0
	CBO estimate	----	0	0	0	0	0
33	Food, Agriculture, Conservation, and Trade Act Amendments of 1991 (H.R. 3029; P.L. 102-237):						
	OMB estimate	—	4	10	12	11	37
	CBO estimate	—	-2	1	*	-1	-2
34	Amendments to the Public Health Service and Controlled Substances Acts (S. 1891; P.L. 102-239):						
	OMB estimate	----	*	*	*	*	*
	CBO estimate	—	0	0	0	0	0
35	Intermodal Surface Transportation Infrastructure Act of 1991 (H.R. 2950; P.L. 102-240):						
	OMB estimate	----	-123	-326	0	-2	-451
	CBO estimate	----	-590	-1,798	-328	0	-2,716
36	Coast Guard Authorization Act of 1991 (H.R. 1776; P.L. 102-241):						
	OMB estimate	—	*	*	*	*	1
	CBO estimate	—	*	*	*	*	1
37	Federal Deposit Insurance Improvement Act of 1991 (S. 543; P.L. 102-242):						
	OMB estimate	----	-389	-200	-100	-100	-789
	CBO estimate	----	3	0	0	-1	2
Total, legislation enacted as of January 3, 1992:							
	OMB estimate	-*	-1,095	-1,136	-476	-1,005	-3,712
	CBO estimate	6	752	-1,762	111	-9	-902

* $500,000 or less.
[1] Estimate of deficit impact of legislation affecting receipts.
[2] Estimate of deficit impact of legislation affecting receipts and outlays.

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